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The Iowa Administrative Code Supplement is published biweekly pursuant to Iowa Code sections 2B.5A and 17A.6. The Supplement contains replacement chapters to be inserted in the loose-leaf Iowa Administrative Code (IAC) according to instructions included with each Supplement. The replacement chapters incorporate rule changes which have been adopted by the agencies and filed with the Administrative Rules Coordinator as provided in Iowa Code sections 7.17 and 17A.4 to 17A.6. To determine the specific changes in the rules, refer to the Iowa Administrative Bulletin bearing the same publication date.

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

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

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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

Editor's telephone (515)281-3355 or (515)242-6873

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CHAPTER 5
PETITIONS FOR RULE MAKING

11—5.1(17A) Petition for rule making.

5.1(1) Filing. Any person or agency may file a petition for adoption of rules or request for review of rules with the Department of Administrative Services, Office of the Director, Hoover State Office Building, Third Floor, Des Moines, Iowa 50319. A petition is deemed filed when it is received by the department. The department shall provide the petitioner with a file-stamped copy of the petition if the petitioner provides the department an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

DEPARTMENT OF ADMINISTRATIVE SERVICES	
Petition by (Name of Petitioner) for the (adoption, amendment, or repeal) of rules relating to (state the subject matter).	} PETITION FOR RULE MAKING

The petition must provide the following information:

- a. A statement of the specific rule-making action sought by the petitioner including the text or a summary of the contents of the proposed rule or amendment to a rule and, if it is a petition to amend or repeal a rule, a citation and the relevant language to the particular portion or portions of the rule proposed to be amended or repealed.
- b. A citation to any law deemed relevant to the department’s authority to take the action urged or to the desirability of that action.
- c. A brief summary of petitioner’s arguments in support of the action urged in the petition.
- d. A brief summary of any data supporting the action urged in the petition.
- e. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by or interested in, the proposed action which is the subject of the petition.
- f. Any request by petitioner for a meeting provided for by rule 11—5.4(17A).

5.1(2) Content. The petition must be dated and signed by the petitioner or the petitioner’s representative. It must also include the name, mailing address, and telephone number of the petitioner and petitioner’s representative, and a statement indicating the person to whom communications concerning the petition should be directed.

5.1(3) Denial. The director may deny a petition because it does not substantially conform to the required form. Denial of a petition because it does not substantially conform to the required form does not preclude the filing of a new petition on the same subject that seeks to eliminate the grounds for the department’s rejection of the petition.

5.1(4) Submission to administrative rules review committee. The department shall submit a petition for rule making and the department’s disposition of the petition to the administrative rules review committee.

[ARC 4053C, IAB 10/10/18, effective 11/14/18; ARC 5512C, IAB 3/10/21, effective 4/14/21]

11—5.2(17A) Briefs. The petitioner may attach a brief to the petition in support of the action urged in the petition. The director may request a brief from the petitioner or from any other person concerning the substance of the petition.

11—5.3(17A) Inquiries. Inquiries concerning the status of a petition for rule making may be made to the director at the offices of the department.

11—5.4(17A) Department consideration.

5.4(1) Upon request by petitioner in the petition, the department must schedule a brief and informal meeting between the petitioner and the department to discuss the petition. The department may request the petitioner to submit additional information or argument concerning the petition. The department may

also solicit comments from any person on the substance of the petition. Also, comments on the substance of the petition may be submitted to the department by any person.

5.4(2) Within 60 days after the filing of the petition, or within any longer period agreed to by the petitioner, the department must, in writing, deny the petition, and notify petitioner of its action and the specific grounds for the denial, or grant the petition and notify petitioner that it has instituted rule-making proceedings on the subject of the petition. The petitioner shall be deemed notified of the denial or grant of the petition on the date when the department mails or delivers the required notification to the petitioner. [ARC 5512C, IAB 3/10/21, effective 4/14/21]

These rules are intended to implement Iowa Code chapters 8A and 17A.

[Filed 11/6/03, Notice 10/1/03—published 11/26/03, effective 2/11/04]

[Filed 10/22/04, Notice 9/15/04—published 11/10/04, effective 12/15/04]

[Filed ARC 4053C (Notice ARC 3937C, IAB 8/15/18), IAB 10/10/18, effective 11/14/18]

[Filed ARC 5512C (Notice ARC 5378C, IAB 1/13/21), IAB 3/10/21, effective 4/14/21]

INSURANCE DIVISION[191]

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

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CHAPTER 2
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

191—2.1(17A,22) Statement of policy. The purpose of this chapter is to facilitate broad public access to open records. It also seeks to facilitate sound division determinations with respect to the handling of confidential records and the implementation of the fair information practices Act. This division is committed to the policies set forth in Iowa Code chapter 22. Division staff will cooperate with members of the public in implementing the provisions of that chapter.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—2.2(17A,22) Definitions. The definitions in Iowa Code section 22.1 are incorporated into this chapter by this reference. In addition to the definitions in rule 191—1.1(502,505), the following definitions apply:

“Confidential record” means a record that is not available as a matter of right for inspection and copying by members of the public under applicable provisions of law. Confidential records include records or information contained in records that the division is prohibited by law from making available for inspection by members of the public, and records or information contained in records that are specified as confidential by Iowa Code section 22.7, or other provisions of law, but that may be disclosed upon order of a court, the lawful custodian of the record, or by another person duly authorized to release the record. Mere inclusion in a record of information declared confidential by an applicable provision of law does not necessarily make that entire record a confidential record.

“Division” means the insurance division of the department of commerce, created by Iowa Code section 505.1. The division is both the “government body” and the “lawful custodian” as defined in Iowa Code sections 22.1(1) and 22.1(2). The division is also the “state agency” as defined in Iowa Code chapter 17A and referenced in Iowa Code chapter 22. For purposes of this chapter, “division” includes both the commissioner of insurance and the administrator as defined in Iowa Code chapter 502.

“File,” “filed,” or “filing,” when used as a verb, means submitting or having submitted to the division a record or information. “File” or “filing,” when used as a noun, means a record or information.

“Inspect” or “inspection” means the same as “examine” or “examination” in Iowa Code chapter 22. The term “examination” in this chapter does not mean the same as “examination” as used in Iowa Code chapter 22.

“Lawful custodian,” as used in Iowa Code section 22.1(2), is the division, the division’s record officer, or an employee lawfully delegated authority by the division to act for the division in implementing Iowa Code chapter 22.

“Open record” means a record other than a confidential record.

“Personally identifiable information” means information about or pertaining to an individual in a record which identifies the individual and which is contained in a record system.

“Record” means all or part of a “public record,” as defined in Iowa Code section 22.1, that is owned by or in the physical possession of the division.

“Record system” means any group of records under the control of the division from which a record may be retrieved by a personal identifier such as the name of the individual, number, symbol or other unique retriever assigned to the individual.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—2.3(17A,22) General provisions.

2.3(1) Entities holding division records covered by this rule. This rule applies to records belonging to, required by, or created by the division. This rule applies to records held by third parties, including other state agencies, that do any of the following:

- a. Perform division functions on behalf of the division;
- b. Store records for the division;
- c. Perform services for the division; or
- d. Otherwise handle records that would be governed by this rule if they were in the possession of the division.

2.3(2) Existing records. A request for access shall apply only to records that exist at the time the request is made and access is provided. The division is not required to create, compile or procure a record solely for the purpose of making it available except as described in Iowa Code section 22.3A and subrule 2.4(6).

2.3(3) Public records. All of the division's records are open records available to the public except for records that are confidential under rule 191—2.12(17A,22) or redactable under rule 191—2.11(17A,22).

2.3(4) Availability of open records. Open records of the division are available to the public for examination and copying unless otherwise provided by state or federal law, regulation or rule.

2.3(5) Internet access. The division provides public access to many public records, with no request for access necessary, on the division's website.

2.3(6) Office hours. Open records are available for inspection during customary office hours, which are 8 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays.

2.3(7) Data processing system. Some agency data processing systems that have common data elements can match, collate and compare personally identifiable information.

2.3(8) Scope. This chapter does not:

a. Require the division to index or retrieve records which contain information about individuals by that person's name or other personal identifier.

b. Make available to the general public records which would otherwise not be available under the public records law, Iowa Code chapter 22.

c. Govern the maintenance or disclosure of, notification of or access to, records in the possession of the division which are governed by the regulations of another agency.

d. Apply to grantees, including local governments or subdivisions thereof, administering state-funded programs.

e. Make available records compiled 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, the Code of Professional Responsibility, and applicable regulations.

f. Make any warranty of the accuracy or completeness of a record.
[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—2.4(17A,22) Requests for access to records.

2.4(1) Request for access. Requests for access to open records not available on the division's website may be made in writing or in person. A request may be made by mail, email, or online as instructed on the division's website. Requests must identify the particular records sought by name or description in order to facilitate the location of the record. Requests must include the name, address, email address if available, and telephone number of the person requesting the information. A person is not required to give a reason for requesting an open record. If the division has records in its possession that may be public records but that are copies of materials from another agency or public organization, the division may refer persons seeking inspection of those records to the originating agency or public organization.

2.4(2) Response to requests.

a. Access. Access to an open record shall be provided promptly upon request unless the size or nature of the request makes prompt access infeasible. If the size or nature of the request for access to an open record requires time for compliance, the division must comply with the request as soon as feasible. The division requests that members of the public make appointments for the in-person inspection of public records because the division needs time to locate stored records and office space is limited.

b. Delay. Access to an open record may be delayed for one of the purposes authorized by Iowa Code section 22.8(4) or 22.10(4), for redaction by the division of confidential information, or for search and review of requested records. The division must promptly give written notice to the requester of the reason for any delay and an estimate of the length of that delay.

c. Deny. The division may deny access to the record by members of the public when warranted under Iowa Code chapter 22 or other applicable law or when the record's disclosure is prohibited by a court order.

2.4(3) Security of record. No person may, without permission from the division, search or remove any record from division files. Inspection and copying of division records must be supervised by the division or a designee of the division in order for the records to be protected from damage and disorganization.

2.4(4) Copying. A reasonable number of copies of an open record may be made in the division's office. If photocopy equipment is not available in the division office where an open record is kept, the division must permit the record's inspection in that office and arrange to have copies promptly made elsewhere.

2.4(5) Fees. The division may charge fees for records as authorized by Iowa Code section 22.3 or another provision of law. Under Iowa Code section 22.3, the fee for the copying service, whether electronic or hard copy, or mailing shall not exceed the cost of providing the service. An hourly fee may be charged for actual division expenses in the inspection, reviewing, and copying of requested records when the total staff time dedicated to fulfilling the request requires an excess of two hours. When the open records request will cause time required in excess of the allotted two hours, the division may require a requester to make an advance payment to cover all of the estimated fee.

2.4(6) Information released. If a person is provided access to less than an entire record, the division shall take measures to ensure that the person is furnished only the information that is to be released. This may be done by providing to the person either an extraction of the information to be released or a copy of the record from which the information not to be released has been otherwise redacted.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—2.5(17A,22) Access to confidential records.

2.5(1) Procedure. The following provisions are in addition to those specified in rule 191—2.4(17A,22) and are minimum requirements. A statute or another administrative rule may impose additional requirements for access to certain classes of confidential records. A confidential record may, due to its nature or the way it is compiled or stored, contain a mixture of confidential and nonconfidential information. The division shall not refuse to release the nonconfidential information simply because of the manner in which the record is compiled or stored.

a. Form of request. The division shall ensure that there is sufficient information to provide reasonable assurance that access to a confidential record may be granted. Therefore, the division may require the requester to:

- (1) Submit the request in writing.
- (2) Provide proof of identity and authority to secure access to the record.

b. Response to request. The division must notify the requester of approval or denial of the request for access. The notice must include:

- (1) The name and title or position of the person responding on behalf of the division; and
- (2) A brief statement of the grounds for denial, including a citation to the applicable statute or other provision of law.

c. Request granted. When the division grants a request for access to a confidential record to a particular person, the division must notify that person and indicate any lawful restrictions imposed by the division on that person's inspection and copying of the record.

d. Reconsideration of denial. A requester whose request is denied by the division may apply to the commissioner of insurance for reconsideration of the request.

2.5(2) Release of confidential records by the division. The division may release a confidential record or a portion of it to:

- a.* The legislative services agency pursuant to Iowa Code section 2A.3.
- b.* The ombudsman pursuant to Iowa Code section 2C.9.
- c.* Other governmental officials and employees only as needed to enable them to discharge their duties.

d. The public information board pursuant to Iowa Code section 23.6.
[ARC 4780C, IAB 11/20/19, effective 12/25/19; ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—2.6(17A,22) Requests for confidential treatment. The division may treat a record as a confidential record and withhold it from inspection or refuse to disclose that record to members of the public only to the extent that the division is authorized by Iowa Code section 22.7, another applicable provision of law, or a court order.

2.6(1) Request. A person may request that all or a portion of a record be confidential. The request for confidential treatment must be submitted in writing to the division and:

- a.* Identify the information for which confidential treatment is sought.
- b.* Cite the legal and factual basis that justifies confidential treatment.
- c.* Identify the name, address, and telephone number of the person authorized to respond to any inquiry or action of the custodian concerning the request.
- d.* Specify the precise period of time for which the confidential treatment is requested should the request be only for a limited time period.

2.6(2) Additional information. The division may request additional factual information from the person to justify treatment of the record as a confidential record.

2.6(3) Decision. The division must notify the requester in writing of the granting or denial of the request and, if the request is denied, the reasoning for the denial.

2.6(4) Request denied. If the request for confidential treatment of a record is denied, the requester may apply to the commissioner for reconsideration of the request. However, the record shall not be withheld from public inspection for any period of time if the division determines that the requester had no reasonable grounds to justify the treatment of that record as a confidential record.

2.6(5) Failure to request. Failure of a person to request confidential record treatment for a record does not preclude the division from treating it as a confidential record. However, if a person who has submitted information to the division does not request that it be withheld from public inspection, the division may proceed as if that person has no objection to its disclosure to members of the public.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—2.7(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records. Except as otherwise provided by law, the person who is the subject of a record may have a written statement of additions, dissents or objections entered into that record. The statement shall be filed with the division. The statement must be dated and signed by the person who is the subject of the record and include the person's current address and telephone number. This rule does not authorize the person who is the subject of the record to alter the original record or to expand the official record of any division proceeding.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—2.8(17A,22) Disclosures without the consent of the subject.

2.8(1) To the extent allowed by law, disclosure of confidential records may occur without the consent of the subject.

2.8(2) Authority to release confidential records. The division 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 these records withheld from inspection under a statute which authorizes limited or discretionary disclosure as provided in rule 191—2.6(17A,22). If the division initially determines that it will release such records, the division may notify interested persons and withhold the records from inspection as provided in rules 191—2.6(17A,22) and 191—2.7(17A,22).

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—2.9(17A,22) Consent to disclosure by the subject of a confidential record. To the extent permitted by any applicable provision of law, the subject of a confidential record may consent to have a copy of the portion of that record that concerns the subject disclosed to a third party. A request for such a disclosure must be in writing and must identify the particular record or records that may be disclosed

and the particular person or class of persons to whom the record may be disclosed. The subject of the record and, where applicable, the person to whom the record is to be disclosed may be required to provide proof of identity. Appearance of counsel before the division on behalf of a person who is the subject of a confidential record is deemed to constitute consent for the division to disclose records about that person to the person's attorney.
[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—2.10(17A,22) Notice to suppliers of information. When the division requests a person to supply information about that person, the division must notify the person of the use that will be made of the information, which persons outside the division might routinely be provided this information, which parts of the requested information are required and which are optional, and the consequences of a failure to provide the information requested. This notice may be given in these rules, on the written form used to collect the information, on a separate fact sheet or letter, in brochures, in formal agreements, in contracts, in handbooks, in manuals, verbally, or by other appropriate means.

2.10(1) Notice. The notice shall generally be given at the first contact with the division and need not be repeated. Where appropriate, the notice may be given to a person's legal or personal representative. Notice may be withheld in an emergency or when it would compromise the purpose of a department investigation.

2.10(2) License and examination applicants. License and examination applicants are requested to supply a wide range of information depending on the qualifications for licensure or sitting for an examination, as provided by division statutes, rules and application forms. Failure to provide requested information may result in denial of the application. Some requested information, such as social security numbers, home addresses, examination scores, and criminal histories, is confidential under state or federal law, but most of the information contained in license or examination applications is treated as public information, freely available for public examination.

2.10(3) License renewal. Licensees are requested to supply a wide range of information in connection with license renewal, including continuing education information, criminal history and disciplinary actions, as provided by division statutes, rules and application forms, both on paper and electronically. Failure to provide requested information may result in denial of the application. Most information contained on renewal applications is treated as public information freely available for public examination, but some information may be confidential under state or federal law.

2.10(4) Investigations. Persons and entities regulated by the division are required to respond to division requests for information as part of the investigation of a complaint or inquiry. Failure to timely respond may result in disciplinary action against the person or entity to which the request is made. Information provided in response to such a request is confidential pursuant to Iowa Code, including but not limited to Iowa Code section 502.607(2), 505.8(8) "a," 507E.5, or 523A.803, but may become public if introduced at a hearing which is open to the public, contained in a final order, or filed with a court of judicial review.

2.10(5) Discovery request, subpoenas, and investigations. Notice need not be given in connection with discovery requests in litigation or administrative proceedings, subpoenas, investigations of possible violations of law or similar demands for information.

2.10(6) Other requested information. In general, pursuant to state or federal law, the division requests information necessary for its regulation of insurance, securities, and regulated industries that is required to be provided to the division. This required information may be shared outside the division when required by state or federal law or division rules. Failure of a regulated entity or person to provide this information may result in the denial of the licensure or regulatory approval, as appropriate, for which the information was requested.

[ARC 4780C, IAB 11/20/19, effective 12/25/19; ARC 4949C, IAB 2/26/20, effective 4/1/20]

191—2.11(17A,22) Personally identifiable information collected by the division. The division collects and maintains open records, some of which may contain personally identifiable information, and some of which may be shared with other state or federal agencies or organizations or vendors. This rule describes the nature and extent of personally identifiable information which is collected,

maintained, and retrieved by the division. Unless otherwise stated, the authority for the collection of the record is provided by Iowa Code chapter 502 or 505. Some personally identifiable information is protected by Iowa Code sections 502.607(2)“e” and 505.8(9).

2.11(1) Nature and extent. The following records may contain personally identifiable information:

a. Confidential records. Records listed as confidential records are described in rule 191—2.12(17A,22).

b. Rule-making records. Rule-making records may contain information about people who make written or oral comments about proposed rules.

c. Contested case records. Contested case records contain names and identifying numbers of people involved. Evidence and documents submitted as a result of a contested case are contained in contested case records.

d. Licensing records. Licensing records of individuals and entities regulated by the division contain names and identifying numbers of the regulated individual or individuals designated as responsible for the regulated entity.

e. Complaint, inquiry, investigation, and examination records. Complaint, inquiry, investigation, and examination records contain names and identifying numbers of the people who submit, are the subject of, or are otherwise involved in the complaint, inquiry, investigation or examination.

f. Personnel files. The division maintains files containing information about employees of the division and applicants for positions with the division. The files contain payroll records, biographical information, medical information relating to disability, performance reviews and evaluations, disciplinary information, information required for tax withholding, information concerning employee benefits, affirmative action reports, and other information concerning the employer-employee relationship.

2.11(2) Redaction. To the extent that the division finds it necessary to allow inspection of records containing personally identifiable information, the division must, when allowed by law, redact the personally identifiable information prior to allowing the inspection.

2.11(3) Means of storage. Paper and various electronic means of storage are used to store records containing personally identifiable information. Some information is stored electronically by third parties on behalf of the division.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—2.12(17A,22) Confidential records. This rule describes the types of agency information or records that are confidential. This rule is not exhaustive. The following records shall be kept confidential. Records are listed by category and include a citation to the legal basis for withholding that category from public inspection.

2.12(1) Records which are exempt from disclosure under Iowa Code section 22.7.

2.12(2) Records which constitute attorney work product, or 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.C.P. 122(c), 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.

2.12(3) Those portions of the division’s staff manuals, instructions or other statements issued by the division which set forth criteria or guidelines to be used by division staff in auditing, making inspections, settling commercial disputes or negotiating commercial arrangements, or in the selection or handling of cases, such as operational tactics or allowable tolerances or criteria for the defense, prosecution or settlement of cases, when the disclosure of such statements would enable law violators to avoid detection, facilitate disregard of requirements imposed by law, or give a clearly improper advantage to persons who are in an adverse position to the division, pursuant to Iowa Code sections 17A.2 and 17A.3.

2.12(4) All information obtained and prepared in the course of an inquiry, complaint, or investigation, including but not limited to communications, insurer documents, data, reports, analysis, and notes, pursuant to Iowa Code section 505.8 and chapters 502, 502A, 505, 507A, 507E, 522B, 523C, and 523I.

2.12(5) Information of insurers designated as confidential by applicable law, including but not limited to information and reports that are part of an examination, pursuant to Iowa Code sections 505.17 and 507.14.

2.12(6) Information of the Iowa life and health guaranty association, pursuant to Iowa Code chapters 508C and 515B.

2.12(7) Insurance holding company systems registration and holding company examinations, pursuant to Iowa Code section 522.7.

2.12(8) Information related to the uniform securities Act that is designated nonpublic pursuant to Iowa Code section 502.607.

2.12(9) Information filed with the division related to preneed sellers and sales agents of cemetery and funeral merchandise and funeral services pursuant to Iowa Code chapter 523A.

2.12(10) Information obtained in the course of an examination of a cemetery pursuant to Iowa Code chapter 523I.

2.12(11) All records relating to prearranged funeral contracts, except upon approval by the commissioner of insurance or the attorney general, pursuant to Iowa Code section 523A.204(3).

2.12(12) 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 section 17A.3(1)“e.”

2.12(13) Sealed bids received prior to the time set for public opening of bids, pursuant to Iowa Code section 72.3.

2.12(14) Information related to external review of health care coverage decisions, pursuant to Iowa Code chapter 514J.

2.12(15) Information related to automobile insurance cancellation, pursuant to Iowa Code chapter 515D.

2.12(16) Determination of any suspension of an insurance producer’s or other licensee’s pending application for licensure, pending request for renewal, or current license, when the suspension is related to failure to pay child support, foster care, or state debt, pursuant to rule 191—10.21(252J). Notwithstanding any statutory confidentiality provision, the division may share information with the child support recovery unit or the centralized collection unit of the department of revenue, through manual or automated means, for the sole purpose of identifying registrants, applicants or licensees subject to enforcement under Iowa Code chapter 252J or 272D, respectively.

2.12(17) Information which is confidential under the law governing a person providing information to the division and pursuant to a written sharing agreement referencing that law and how it applies to allow the division to share the information.

2.12(18) All other information or records that by law are or may be confidential.
[ARC 4780C, IAB 11/20/19, effective 12/25/19; ARC 5515C, IAB 3/10/21, effective 4/14/21]

These rules are intended to implement Iowa Code section 22.11.

[Filed ARC 4780C (Notice ARC 4660C, IAB 9/25/19), IAB 11/20/19, effective 12/25/19]

[Filed ARC 4949C (Notice ARC 4840C, IAB 1/1/20), IAB 2/26/20, effective 4/1/20]

[Filed ARC 5515C (Notice ARC 5389C, IAB 1/13/21), IAB 3/10/21, effective 4/14/21]

REGULATION OF INSURERS

CHAPTER 5

REGULATION OF INSURERS—GENERAL PROVISIONS

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

191—5.1(505,507,508,515) Definitions. The definitions in rule 191—1.1(502,505) apply to this chapter.

This rule is intended to implement Iowa Code chapters 505, 507, 508, and 515.
[ARC 5515C, IAB 3/10/21, effective 4/14/21]

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

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

This rule is intended to implement Iowa Code section 507.2.
[ARC 5515C, IAB 3/10/21, effective 4/14/21]

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

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

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

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

[ARC 5515C, IAB 3/10/21, effective 4/14/21]

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

- 5.6(1) Real estate.** At amortized cost.
- 5.6(2) Stocks.** At market value as determined by the Securities Valuation Office of the National Association of Insurance Commissioners.
- 5.6(3) Bonds.** At amortized cost, unless directed otherwise by the commissioner.
- 5.6(4) Artwork.** Nonadmitted.
- 5.6(5) Other assets not listed.** As treated by the applicable accounting practices and procedures manual of the National Association of Insurance Commissioners.
- 5.6(6) Liabilities.** Liabilities, including active life reserves, unearned premium reserves, and liabilities for claims and losses unpaid and for incurred but not reported claims. As determined by

the applicable accounting practices and procedures manual of the National Association of Insurance Commissioners.

[ARC 5515C, IAB 3/10/21, effective 4/14/21]

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

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

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

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

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

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

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

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

191—5.11(511) Investment of funds. Rescinded ARC 5515C, IAB 3/10/21, effective 4/14/21.

191—5.12(515) Collateral loans. The collateral pledged to secure a loan must qualify as a legal investment for insurance companies before the loan it secures may so qualify [Iowa Code section 515.35(3) “a”(2)]. The statute provides that a company may not invest in excess of 30 percent of its capital and funds in stocks and not more than 10 percent of its capital and surplus in the stock or bonds, or both, of any one corporation.

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

[ARC 5515C, IAB 3/10/21, effective 4/14/21]

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

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

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

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

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

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

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

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

191—5.16 to 5.19 Reserved.

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

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

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

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

UNEARNED PREMIUM RESERVES ON MORTGAGE GUARANTY INSURANCE POLICIES

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

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

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

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

191—5.23(507C) Standards. Rescinded **ARC 5515C**, IAB 3/10/21, effective 4/14/21.

191—5.24(507C) Commissioner's authority. Rescinded **ARC 5515C**, IAB 3/10/21, effective 4/14/21.

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

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

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

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

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

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

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

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

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

This rule is intended to implement Iowa Code sections 508.11 and 515.63.
[ARC 5515C, IAB 3/10/21, effective 4/14/21]

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

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

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

5.27(2) The division shall have full discretion in determining the method of calculating values according to the procedures set forth in this rule, but no such method or valuation shall be inconsistent with any applicable valuation or method used by insurers in general, or any method formulated or approved by the National Association of Insurance Commissioners or its successor organization.

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

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

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

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

191—5.28(508,515,518,518A,520) Risk-based capital and surplus. Capital and surplus requirements in Iowa Code chapters 508, 515, 518, 518A and 520 are minimums. The commissioner retains the discretion to require greater amounts than set forth in those chapters when the risk-based circumstances of a particular insurer, including the type, nature and volume of business being written, require it.
[ARC 5515C, IAB 3/10/21, effective 4/14/21]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.32(4) Provisions.

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

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

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

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

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

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

d. Notwithstanding the foregoing, a domestic insurer may acquire an obligation of an institution in which the insurer already has one or more obligations if the obligation is acquired in order to protect

an investment previously made in the obligations of the institution, provided that all such acquired obligations shall not exceed one-half of 1 percent of the insurer's admitted assets.

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

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

g. The board of directors of any domestic insurance company which acquires or invests, directly or indirectly, more than 2 percent of its admitted assets in medium grade and lower grade obligations of any institution shall adopt a written plan for the making of such investments. The plan, in addition to guidelines with respect to the quality of the issues invested in, shall contain diversification standards including, but not limited to, standards for issuer, industry, duration, liquidity and geographic location.

This rule is intended to implement Iowa Code sections 511.8 and 515.35.
[ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—5.33(510) Credit for reinsurance.

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

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

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

5.33(4) Accredited reinsurers.

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

(1) Files a properly executed Form AR-1¹ as evidence of its submission to this state's jurisdiction and to this state's authority to examine its books and records;

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

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

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

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

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

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

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

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

(3) Files a properly executed Form AR-1¹ with the commissioner as evidence of its submission to this state's authority to examine its books and records.

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

5.33(6) *Reinsurers maintaining trust funds.*

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

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

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

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

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

(4) At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trustee surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including, when applicable, the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the

assuming insurer's liquidity or solvency. The minimum required trustee surplus may not be reduced to an amount less than 30 percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.

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

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

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

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

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

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

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

5.33(7) Certified reinsurers.

a. The commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that has been certified as a reinsurer in this state at all times for which statutory financial statement credit for reinsurance is claimed under this subrule. The credit allowed shall be based upon the security held by or on behalf of the ceding insurer in accordance with a rating assigned to the certified reinsurer by the commissioner. The security shall be in a form consistent with subrules 5.33(11), 5.33(12), and 5.33(13) of this rule and Iowa Code sections 521B.102(5) and 521B.103. The amount of security required in order for full credit to be allowed shall correspond with the following requirements:

(1) Ratings/security.

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

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

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

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

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

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

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

b. Certification procedure.

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

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

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

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

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

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

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

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

(4) Each certified reinsurer shall be rated on a legal entity basis, with due consideration being given to the group rating where appropriate, except that an association including incorporated and individual unincorporated underwriters that has been approved to do business as a single certified reinsurer may

be evaluated on the basis of its group rating. Factors that may be considered as part of the evaluation process include, but are not limited to, the following:

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

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

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

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

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

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

6. Regulatory actions against the certified reinsurer.

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

8. For certified reinsurers not domiciled in the United States, audited financial statements, regulatory filings, and actuarial opinion (as filed with the non-United States jurisdiction supervisor, with a translation into English). Upon the initial application for certification, the commissioner will consider audited financial statements for the last two years filed with the certified reinsurer's non-United States jurisdiction supervisor.

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

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

11. Any other information deemed relevant by the commissioner.

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

reinsurer is required to post by one rating level under paragraph 5.33(7) "b"(4)"1" if the commissioner finds that:

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

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

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

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

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

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

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

4. Annually, the most recent audited financial statements, regulatory filings, and actuarial opinion (as filed with the certified reinsurer's supervisor, with a translation into English). Upon the initial certification, audited financial statements for the last two years filed with the certified reinsurer's supervisor.

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

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

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

(8) Change in rating or revocation of certification.

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

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

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

4. Upon revocation of the certification of a certified reinsurer by the commissioner, the assuming insurer shall be required to post security in accordance with subrule 5.33(10) of this rule in order for

the ceding insurer to continue to take credit for reinsurance ceded to the assuming insurer. If funds continue to be held in trust in accordance with subrule 5.33(6) of this rule, the commissioner may allow additional credit equal to the ceding insurer's pro rata share of such funds, discounted to reflect the risk of uncollectibility and anticipated expenses of trust administration. Notwithstanding the change of a certified reinsurer's rating or revocation of its certification, a domestic insurer that has ceded reinsurance to that certified reinsurer may not be denied credit for reinsurance for a period of three months for all reinsurance ceded to that certified reinsurer, unless the reinsurance is found by the commissioner to be at high risk of uncollectibility.

c. Qualified jurisdictions.

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

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

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

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

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

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

(1) If an applicant for certification has been certified as a reinsurer in an NAIC-accredited jurisdiction, the commissioner has the discretion to defer to that jurisdiction's certification, and to defer to the rating assigned by that jurisdiction, if the assuming insurer submits a properly executed Form CR-1 and such additional information as the commissioner requires. The assuming insurer shall be considered to be a certified reinsurer in this state.

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

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

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

e. Mandatory funding clause. In addition to the clauses required under subrule 5.33(14) of this rule, reinsurance contracts entered into or renewed under this subrule shall include a proper funding clause, which requires the certified reinsurer to provide and maintain security in an amount sufficient to avoid the imposition of any financial statement penalty on the ceding insurer under this subrule for reinsurance ceded to the certified reinsurer.

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

5.33(8) Credit for reinsurance—reciprocal jurisdictions.

a. Pursuant to Iowa Code section 521B.102(5A), the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that is licensed to write reinsurance by, and has its head office or is domiciled in, a reciprocal jurisdiction, and which meets the other requirements of this subrule.

b. A "reciprocal jurisdiction" is a jurisdiction, as designated by the commissioner pursuant to paragraph 5.33(8) "d," that meets one of the following:

(1) A non-U.S. jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and the European Union, is a member state of the European Union. For the purposes of this subrule, a "covered agreement" is an agreement entered into pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. Sections 313 and 314, that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance.

(2) A U.S. jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program.

(3) A qualified jurisdiction, as determined by the commissioner pursuant to Iowa Code section 521B.102(5) "c" and paragraph 5.33(7) "c," which is not otherwise described in subparagraph 5.33(8) "b"(1) or (2) and which the commissioner determines meets all of the following additional requirements:

1. Provides that an insurer which has its head office or is domiciled in such qualified jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance is received for reinsurance assumed by insurers domiciled in such qualified jurisdiction.

2. Does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation

by the non-U.S. jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance.

3. Recognizes the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by a competent regulatory authority, in such qualified jurisdiction, that insurers and insurance groups that are domiciled or maintain their headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the commissioner or the commissioner of the domiciliary state and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the qualified jurisdiction.

4. Provides written confirmation by a competent regulatory authority in such qualified jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the commissioner in accordance with a memorandum of understanding or similar document between the commissioner and such qualified jurisdiction, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC.

c. Credit shall be allowed when the reinsurance is ceded from an insurer domiciled in this state to an assuming insurer meeting each of the conditions set forth below.

(1) The assuming insurer must be licensed to transact reinsurance by, and have its head office or be domiciled in, a reciprocal jurisdiction.

(2) The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, and confirmed as set forth in subparagraph 5.33(8)“c”(7) according to the methodology of its domiciliary jurisdiction, in the following amounts:

1. No less than \$250 million; or

2. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, meets both of the following:

- Minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least \$250 million.

- A central fund containing a balance of the equivalent of at least \$250 million.

(3) The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio, as applicable, one of the following:

1. If the assuming insurer has its head office or is domiciled in a reciprocal jurisdiction as defined in subparagraph 5.33(8)“b”(1), the ratio specified in the applicable covered agreement.

2. If the assuming insurer is domiciled in a reciprocal jurisdiction as defined in subparagraph 5.33(8)“b”(2), a risk-based capital (RBC) ratio of 300 percent of the authorized control level, calculated in accordance with the formula developed by the NAIC.

3. If the assuming insurer is domiciled in a reciprocal jurisdiction as defined in subparagraph 5.33(8)“b”(3), after consultation with the reciprocal jurisdiction and considering any recommendations published through the NAIC Committee Process, such solvency or capital ratio as the commissioner determines to be an effective measure of solvency.

(4) The assuming insurer must agree to and provide adequate assurance, in the form of a properly executed Certificate of Reinsurer Domiciled in Reciprocal Jurisdiction Form RJ-1, of its agreement to all of the following:

1. The assuming insurer must agree to provide prompt written notice and explanation to the commissioner if it falls below the minimum requirements set forth in subparagraph 5.33(8)“c”(2) or (3), or if any regulatory action is taken against it for serious noncompliance with applicable law.

2. The assuming insurer must consent in writing to the jurisdiction of the courts in this state and to the appointment of the commissioner as agent for service of process.

- The commissioner may also require that such consent be provided and included in each reinsurance agreement under the commissioner’s jurisdiction.

- Nothing in this provision shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws.

3. The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer, that have been declared enforceable in the territory where the judgment was obtained.

4. Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to 100 percent of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its estate, if applicable.

5. The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement, which involves this state's ceding insurers, and agrees to notify the ceding insurer and the commissioner and to provide 100 percent security to the ceding insurer consistent with the terms of the scheme, should the assuming insurer enter into such a solvent scheme of arrangement. Such security shall be in a form consistent with the provisions of Iowa Code section 521B.103 and subrules 5.33(11), 5.33(12) and 5.33(13). For purposes of this subrule, the term "solvent scheme of arrangement" means a foreign or alien statutory or regulatory compromise procedure subject to requisite majority creditor approval and judicial sanction in the assuming insurer's home jurisdiction either to finally commute liabilities of duly noticed classed members or creditors of a solvent debtor, or to reorganize or restructure the debts and obligations of a solvent debtor on a final basis, and which may be subject to judicial recognition and enforcement of the arrangement by a governing authority outside the ceding insurer's home jurisdiction.

6. The assuming insurer must agree in writing to meet the applicable information filing requirements as set forth in subparagraph 5.33(8) "c"(5).

(5) The assuming insurer or its legal successor must provide, if required by the commissioner, on behalf of itself and any legal predecessors, the following documentation to the commissioner:

1. For the two years preceding entry into the reinsurance agreement and on an annual basis thereafter, the assuming insurer's annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report.

2. For the two years preceding entry into the reinsurance agreement, the solvency and financial condition report or actuarial opinion, if filed with the assuming insurer's supervisor.

3. Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, an updated list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States.

4. Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, information regarding the assuming insurer's assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer to allow for the evaluation of the criteria set forth in subparagraph 5.33(8) "c"(6).

(6) The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment will be evidenced if any of the following criteria is met:

1. More than 15 percent of the reinsurance recoverable from the assuming insurer is overdue and in dispute as reported to the commissioner.

2. More than 15 percent of the assuming insurer's ceding insurers or reinsurers have overdue reinsurance recoverable on paid losses of 90 days or more which are not in dispute and which exceed for each ceding insurer \$100,000, or as otherwise specified in a covered agreement.

3. The aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by 90 days or more, exceeds \$50 million, or as otherwise specified in a covered agreement.

(7) The assuming insurer's supervisory authority must confirm to the commissioner on an annual basis that the assuming insurer complies with the requirements set forth in subparagraphs 5.33(8) "c"(2) and (3).

(8) Nothing in this provision precludes an assuming insurer from providing the commissioner with information on a voluntary basis.

d. The commissioner shall timely create and publish a list of reciprocal jurisdictions.

(1) A list of reciprocal jurisdictions is published through the NAIC committee process. The commissioner's list shall include any reciprocal jurisdiction as defined under subparagraphs 5.33(8) "b"(1) and (2), and shall consider any other reciprocal jurisdiction included on the NAIC list. The commissioner may approve a jurisdiction that does not appear on the NAIC list of reciprocal jurisdictions as provided by applicable law, rule, or in accordance with criteria published through the NAIC committee process.

(2) The commissioner may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets one or more of the requirements of a reciprocal jurisdiction, as provided by applicable law, rule, or in accordance with a process published through the NAIC committee process, except that the commissioner shall not remove from the list a reciprocal jurisdiction as defined under subparagraphs 5.33(8) "b"(1) and (2). Upon removal of a reciprocal jurisdiction from this list credit for reinsurance ceded to an assuming insurer domiciled in that jurisdiction shall be allowed, if otherwise allowed pursuant to Iowa Code chapter 521B or rule 191—5.33(510).

e. The commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this section and to which cessions shall be granted credit in accordance with this section.

(1) If an NAIC-accredited jurisdiction has determined that the conditions set forth in paragraph 5.33(8) "c" have been met, the commissioner has the discretion to defer to that jurisdiction's determination, and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit in accordance with this subrule. The commissioner may accept financial documentation filed with another NAIC-accredited jurisdiction or with the NAIC in satisfaction of the requirements of paragraph 5.33(8) "c."

(2) When requesting that the commissioner defer to another NAIC-accredited jurisdiction's determination, an assuming insurer must submit a properly executed Form RJ-1 and additional information as the commissioner may require. A state that has received such a request will notify other states through the NAIC committee process and provide relevant information with respect to the determination of eligibility.

f. If the commissioner determines that an assuming insurer no longer meets one or more of the requirements under this section, the commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this subrule.

(1) While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with subrule 5.33(10).

(2) If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the commissioner and consistent with the provisions of subrule 5.33(10).

g. Before denying statement credit or imposing a requirement to post security with respect to paragraph 5.33(8) "f" or adopting any similar requirement that will have substantially the same regulatory impact as security, the commissioner shall:

(1) Communicate with the ceding insurer, the assuming insurer, and the assuming insurer's supervisory authority that the assuming insurer no longer satisfies one of the conditions listed in paragraph 5.33(8) "c."

(2) Provide the assuming insurer with 30 days from the initial communication to submit a plan to remedy the defect, and 90 days from the initial communication to remedy the defect, except in exceptional circumstances in which a shorter period is necessary for policyholder and other consumer protection.

(3) After the expiration of 90 days or less, as set out in subparagraph 5.33(8)“g”(2), if the commissioner determines that no or insufficient action was taken by the assuming insurer, the commissioner may impose any of the requirements as set out in this subrule.

(4) Provide a written explanation to the assuming insurer of any of the requirements set out in this subrule.

h. If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding liabilities.

5.33(9) *Credit for reinsurance required by law.* The commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of this state, but only with respect to the insurance of risks located in jurisdictions where such reinsurance is required by the applicable law or regulation of that jurisdiction. As used in this subrule, “jurisdiction” means any state, district or territory of the United States and any lawful national government.

5.33(10) *Reduction from liability for reinsurance ceded to an unauthorized assuming insurer.* The commissioner shall allow a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of this state in an amount not exceeding the liabilities carried by the ceding insurer. Such reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the exclusive benefit of the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder. Such security must be held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer or, in the case of a trust, held in a qualified United States financial institution. This security may be in the form of any of the following:

a. Cash.

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

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

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

5.33(11) *Letters of credit qualified under subrule 5.33(10).*

a. Definitions. As used in this rule:

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

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

“*Obligations*” means:

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

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

b. Required conditions:

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

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

(3) All assets in the trust account shall be held by the trustee at the trustee’s office in the United States, except that a bank may apply for the commissioner’s permission to use a foreign branch office of such bank as trustee for trust agreements established pursuant to this subrule. If the commissioner approves the use of such foreign branch office as trustee, then its use must be approved by the beneficiary in writing and the trust agreement must provide that the written notice described in subparagraph 5.33(11)“b”(4) must also be presentable, as a matter of legal right, at the trustee’s principal office in the United States.

(4) The trust agreement shall provide that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer, in any qualified United States financial institution apart from its general assets, in trust for such uses and purposes specified in subparagraph 5.33(11) "d"(1) as may remain executory after such withdrawal and for any period after the termination date.

(12) The reinsurance agreement entered into in conjunction with the trust agreement may, but need not, contain the provisions required by subparagraph 5.33(11) "d"(1) so long as these required conditions are included in the trust agreement.

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

c. Permitted conditions.

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

(2) The grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive from time to time payments of any dividends or interest upon any shares of stock or obligations included in the trust account. Any such interest or dividends shall be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.

(3) The trustee may be given authority to invest, and accept substitutions of, any funds in the account, provided that no investment or substitution shall be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions which the trustee determines are at least equal in market value to the assets withdrawn and that are consistent with the restrictions in 5.33(11) "d"(1) "2."

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

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

d. Additional conditions applicable to reinsurance agreements.

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

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

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

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

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

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

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

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

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

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

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

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

- The assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount, or

- After withdrawal and transfer, the market value of the trust account is not less than 102 percent of the required amount.

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

2. Provide for:

- The return of any amount withdrawn in excess of the actual amounts required to comply with 5.33(11)“d”(1)“5,” first three bulleted paragraphs, or in the case of 5.33(11)“d”(1)“5,” fourth bulleted paragraph, any amounts that are subsequently determined not to be due; and

- Interest payments, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to 5.33(11)“d”(1)“5,” third bulleted paragraph.

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

- Interest at a rate different from that provided in 5.33(11)“d”(2)“2”;

- Court of arbitration costs;

- Attorney’s fees;

- Any other reasonable expenses.

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

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

(5) The failure of any trust agreement to specifically identify the beneficiary as defined in paragraph 5.33(11)“a” shall not be construed to affect any actions or rights which the commissioner may take or possess pursuant to the provisions of the laws of this state.

5.33(12) Letters of credit qualified under subrule 5.33(10).

a. The letter of credit must be clean, irrevocable and unconditional and issued or confirmed by a qualified United States financial institution. The letter of credit shall contain an issue date and date of expiration and shall stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented. The letter of credit shall also indicate that it is not subject to any condition or qualifications outside of the letter of credit. In addition, the letter of credit itself shall not contain reference to any other agreements, documents or entities, except as provided in subparagraph 5.33(12)“i”(1). As used in this paragraph, “beneficiary” means the domestic insurer for whose benefit the letter of credit has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court-appointed domiciliary receiver (including conservator, rehabilitator or liquidator).

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

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

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

e. The letter of credit shall state whether it is subject to and governed by the laws of this state or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce Publication 600 (UCP 600) or International Standby Practices of the International Chamber

of Commerce Publication 590 (ISP98), or any successor publication, and all drafts drawn thereunder shall be presentable at an office in the United States of a qualified United States financial institution.

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

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

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

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

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

i. Reinsurance agreement provisions.

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

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

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

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

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

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

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

3. All of the provisions required by paragraph 5.33(12) “i” should be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.

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

1. An interest payment, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to 5.33(12) “i”(1)“2,” third bulleted paragraph.

2. The return of any amounts drawn down on the letters of credit in excess of the actual amounts required for the above or, in the event 5.33(12) “i”(1)“2,” fourth bulleted paragraph, is applicable, any amounts that are subsequently determined not to be due.

(3) When a letter of credit is obtained in conjunction with a reinsurance agreement covering risks other than life, annuities and health, where it is customary practice to provide a letter of credit for a specific purpose, then the reinsurance agreement may, in lieu of 5.33(12) “i”(1)“2,” require that the parties enter into a “Trust Agreement” which may be incorporated into the reinsurance agreement or be a separate document.

j. A letter of credit may not be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with this division unless an acceptable letter of credit with the filing ceding insurer as beneficiary has been issued on or before the date of filing of the financial statement. Further, the reduction for the letter of credit may be up to the amount available under

the letter of credit but no greater than the specific obligation under the reinsurance agreement which the letter of credit was intended to secure.

5.33(13) Other security. A ceding insurer may take credit for unencumbered funds withheld by the ceding insurer in the United States subject to withdrawal solely by the ceding insurer and under its exclusive control.

5.33(14) Reinsurance contract. Credit will not be granted, nor an asset or reduction from liability allowed, to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of subrule 5.33(4), 5.33(5), 5.33(6), 5.33(7), 5.33(9), or 5.33(11) after the adoption of this rule unless the reinsurance agreement:

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

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

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

5.33(15) Contracts affected. All new and renewal reinsurance transactions entered into after January 1, 2014, shall conform to the requirements of this rule if credit is to be given to the ceding insurer for such reinsurance.

5.33(16) Severability. If any provision of this rule, or the application of the provision to any person or circumstance, is held invalid, the remainder of the rule, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

This rule is intended to implement Iowa Code chapter 521B.

[ARC 1111C, IAB 10/16/13, effective 1/1/14; ARC 1279C, IAB 1/8/14, effective 2/12/14; ARC 5514C, IAB 3/10/21, effective 4/14/21; ARC 5515C, IAB 3/10/21, effective 4/14/21]

¹ Available from Insurance Division

191—5.34(508) Actuarial opinion and memorandum.

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

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

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

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

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

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

This rule shall be applied in a manner that allows the appointed actuary to utilize the actuary’s professional judgment in performing the asset analysis and developing the actuarial opinion and supporting memoranda, consistent with relevant actuarial standards of practice. However, the commissioner shall have the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the commissioner’s judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items.

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

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

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

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

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

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

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

“*Commissioner*” means the insurance commissioner of this state.

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

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

5.34(5) General requirements.

a. Submission of statement of actuarial opinion.

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

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

b. Qualified actuary. A “qualified actuary” is an individual who:

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

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

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

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

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

2. Been found guilty of fraudulent or dishonest practices;

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

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

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

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

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

respect to this person, provided that the company shall give the commissioner timely written notice in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements set forth in 5.34(5) "b." If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice shall so state and give the reasons for replacement.

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

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

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

e. Liabilities to be covered.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Asset Adequacy Tested Amounts – Reserves and Liabilities					
Statement Item	Formula Reserves (1)	Additional Actuarial Reserves (a) (2)	Analysis Method (b)	Other Amount (3)	Total Amount (1)+(2)+(3) (4)
Exhibit 5 A Life Insurance					
B Annuities					
C Supplementary Contracts Involving Life Contingencies					
D Accidental Death Benefit					
E Disability—Active					
F Disability—Disabled					
G Miscellaneous					
Total (Exhibit 5 Item 1, Page 3)					
Exhibit 6 A Active Life Reserve					
B Claim Reserve					
Total (Exhibit 6 Item 2, Page 3)					
Exhibit 7 Premiums and Other Deposit Funds (Column 5, Line 14)					
Guaranteed Interest Contracts (Column 2, Line 14)					
Other (Column 6, Line 14)					
Supplemental Contracts and Annuities (Column 3, Line 14)					
Dividend Accumulations or Refunds (Column 4, Line 14)					
Total Exhibit 7 (Column 1, Line 14)					
Exhibit 8, Part 1 I Life (Page 3, Line 4.1)					

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

Notes:

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

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

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

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

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

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

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

“In forming my opinion on [specify types of reserves], I relied upon data prepared by [name and title of company officer certifying in-force records or other data] as certified in the attached statements. I evaluated that data for reasonableness and consistency. I also reconciled that data to [exhibits and schedules to be listed as applicable] of the company’s current annual statement. In other respects, my examination included review of the actuarial assumptions and actuarial methods used and tests of the calculations I considered necessary.”

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

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

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

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

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

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

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

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

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

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

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

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

Signature of Appointed Actuary

Address of Appointed Actuary

Telephone Number of Appointed Actuary

Date”

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

d. Adverse opinion. If the appointed actuary is unable to form an opinion, then the actuary shall refuse to issue a statement of actuarial opinion. If the appointed actuary’s opinion is adverse or qualified, then the actuary shall issue an adverse or qualified actuarial opinion explicitly stating the reason(s) for the opinion. This statement should follow the scope paragraph and precede the opinion paragraph.

e. Reliance on information furnished by other persons. If the appointed actuary relies on the certification of others on matters concerning the accuracy or completeness of any data underlying the actuarial opinion, or the appropriateness of any other information used by the appointed actuary in forming the actuarial opinion, the actuarial opinion should so indicate the persons upon whom the actuary is relying and a precise identification of the items subject to reliance. In addition, the persons on whom the appointed actuary relies shall provide a certification that precisely identifies the items on which the person is providing information and a statement as to the accuracy, completeness or

reasonableness, as applicable, of the items. This certification shall include the signature, title, company, address and telephone number of the person rendering the certification, as well as the date on which it is signed.

f. Alternate option.

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

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

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

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

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

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

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

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

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

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

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

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

a. General.

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

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

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

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

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

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

(1) For reserves:

1. Product descriptions including market description, underwriting and other aspects of a risk profile and the specific risks the appointed actuary deems significant;

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

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

(2) For assets:

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

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

(3) For the analysis basis:

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

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

(5) Conclusion(s).

c. Details of the regulatory asset adequacy issues summary.

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

1. Descriptions of the scenarios tested (including whether those scenarios are stochastic or deterministic) and the sensitivity testing done relative to those scenarios. If negative ending surplus results under certain tests in the aggregate, the actuary should describe those tests and the amount of

additional reserves as of the valuation date which, if held, would eliminate the negative aggregate surplus values. Ending surplus values shall be determined by either extending the projection period until the in-force and associated assets and liabilities at the end of the projection period are immaterial or by adjusting the surplus amount at the end of the projection period by an amount that appropriately estimates the value that can reasonably be expected to arise from the assets and liabilities remaining in force;

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

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

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

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

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

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

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

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

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

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

This rule is intended to implement Iowa Code section 508.36.

[ARC 9184B, IAB 11/3/10, effective 12/8/10; ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—5.35 to 5.39 Reserved.

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

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

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

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

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

- a. The insurance company is subject to an order of liquidation or equivalent order issued by a court of competent jurisdiction; or
- b. The insurance company has not written any business in the state of Iowa for five years; or
- c. The insurance company's certificate of authority is voluntarily or involuntarily surrendered or terminated; upon application for a refund, the company shall be prohibited from applying for readmission in Iowa for at least five years; and

- d. The insurance company has no insurer within its holding company which could utilize the credit.

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

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

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

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

This rule is intended to implement Iowa Code section 432.1(6).
[ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—5.43(510) Managing general agents.

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

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

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

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

5.43(5) The amount of claims in excess of which a person is authorized to adjust or pay for purposes of the definition of “managing general agent” in Iowa Code section 510.1B(4) “a”(3)(a) is \$15,000 per claim.

[ARC 5515C, IAB 3/10/21, effective 4/14/21]

DISCLOSURE OF MORTGAGE LOAN APPLICATIONS

191—5.44 to 5.49 Reserved.

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

191—5.51(535A) Definitions.

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

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

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

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

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

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

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

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

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

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

191—5.52(535A) Filing of reports.

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

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

[ARC 5515C, IAB 3/10/21, effective 4/14/21]

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

5.53(1) Reports required by rule 191—5.53(535A) shall be filed on Disclosure Form A¹ or a form similar thereto.

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

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

- a. Name and address of the reporting financial institution.
- b. Name, address and telephone number of the officer designated by the reporting financial institution to file the report.
- c. Reporting period.
- d. The principal amount of a loan shall be disclosed with respect to construction loan applications, home improvement loan applications, total mortgage loan applications, and residential mortgage loan applications, and the requested amount shall be disclosed with respect to construction loan applications not approved, home improvement loan applications not approved, total mortgage loan applications not approved and residential mortgage loan applications not approved. The principal and requested amount disclosures required above shall be reported separately for each census tract or zip code area.

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

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

191—5.54(535A) Additional information required.

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

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

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

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

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

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

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

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

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

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

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

[ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—5.55(535A) Written complaints. Any person who has reason to believe that a financial institution has failed to comply with the provisions of Iowa Code chapter 535A or these rules may file a written

complaint with the division or bring an action in the district court in accordance with Iowa Code chapter 535A.

[ARC 5515C, IAB 3/10/21, effective 4/14/21]

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

191—5.56 to 5.89 Reserved.

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

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[Filed ARC 5515C (Notice ARC 5389C, IAB 1/13/21), IAB 3/10/21, effective 4/14/21]

[◇] Two or more ARCs

CHAPTER 40
HEALTH MAINTENANCE ORGANIZATIONS

(Health and Insurance—Joint Rules)
Appeared as Ch 12, July 1974 Supplement
[Prior to 10/22/86, Insurance Department [510]]

PREAMBLE

The following rules developed by the division of insurance govern the organization and regulation of health maintenance organizations pursuant to the authority set forth in Iowa Code chapter 514B.

191—40.1(514B) Definitions.

“*Act*” when used in these rules shall mean Iowa Code chapter 514B.

“*Complaint*” means a written communication expressing a grievance concerning a health maintenance organization.

“*Dental care*” means care by licensed dentists or by appropriate auxiliary dental personnel working under the supervision of a dentist. It includes the necessary diagnostic, treatment, and preventive services required to maintain proper oral health.

“*Governing body*” means the persons in which the ultimate responsibility and authority for the conduct of the HMO is vested.

“*HMO*” means health maintenance organization and shall be abbreviated as HMO in these rules.

“*Inpatient hospital care*” means inpatient hospital care provided through a licensed hospital on a 24-hour basis.

“*Outpatient medical services*” means outpatient medical services provided within or outside of a hospital. This shall include, but not be limited to, laboratory and diagnostic X-ray with emphasis directed toward primary care.

“*Physician care*” means care by a licensed physician or by paramedical or other ancillary health personnel under the direction of the licensed physician. It shall be of sufficient type and amount to adequately provide for the contracted services including emergency care, inpatient hospital care, and outpatient medical services.

191—40.2(514B) Application. An application on forms provided by the insurance division accompanied by a filing fee of \$100 payable to State Treasurer, State of Iowa, shall be completed by an officer or authorized representative of the health maintenance organization. The application with copies in duplicate shall be verified and shall be accompanied by the information found in Iowa Code section 514B.3(1). An application shall not be deemed to be filed until all information necessary to properly process said application has been received by the commissioner. See 191—40.11(514B).

An amendment to the application form shall be filed in the same manner as the application and approved by the commissioner before the change proposed by the amendment is effective.

[ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—40.3(514B) Inspection of evidence of coverage. An enrollee may, if evidence of coverage is not satisfactory for any reason, return evidence of coverage within ten days of receipt of same and receive full refund of the deposit paid, if any. This right shall not act as a cure for misleading or deceptive advertising or marketing methods, nor may it be exercised if the enrollee utilizes the services of the HMO within the ten-day period.

191—40.4(514B) Governing body and enrollee representation. An HMO shall have a basic written organizational document setting forth its scheme of organization and establishing a governing body appropriate to its form of organization. The governing body shall be responsible for matters of policy and operation.

The HMO shall develop bylaws or guidelines which describe the scope of the health care services the HMO renders to enrollees either directly by its medical staff or dental staff, if dental care is provided, or

through arrangements with others outside of the organization. Initial bylaws, guidelines, and revisions thereto shall be submitted to the commissioner of insurance for review and approval.

The bylaws, guidelines, or similar document shall provide for “reasonable representation” on the governing body by enrollees. “Reasonable representation” as used in Iowa Code section 514B.7 shall require not less than 30 percent of the governing board members be enrollees who are not providers or are not associated with a provider. Enrollees shall have the opportunity to nominate said enrollee representatives.

The HMO may provide upon its initial formation that all representatives on the governing board shall be selected by the organizers of the HMO. Such members shall serve until the first annual meeting or election. If there are no enrollee representatives on the initial governing board, they shall be elected at the first annual meeting or election.

The nomination procedures for enrollee representatives should provide for the following to assure an adequate opportunity for participation by enrollees:

40.4(1) An opportunity for adult enrollees to nominate candidates for the governing body.

40.4(2) Notice to all adult enrollees of the nomination and election procedures.

The HMO shall be deemed to have complied with these requirements if it provides notice in its regular newsletter to enrollees of the opportunity to and the procedures for nomination of enrollee representatives.

Nomination procedures may be waived by the commissioner for a period of up to three years from the HMO’s commencement of delivery of services to enrollees.

For purposes of this rule, an HMO operated directly by a corporation or corporations subject to Iowa Code chapter 514 and rule 191—34.7(514) shall be deemed to be in compliance with this rule if it is or they are in compliance with Iowa Code section 514.4 and rule 191—34.7(514).

This rule is intended to implement Iowa Code section 514B.7.

191—40.5(514B) Quality of care. Each HMO shall:

40.5(1) Provide primary care physicians’ services commensurate with the need of the enrollees, but at a level of not less than that established in the community.

40.5(2) Advise the insurance division annually pursuant to Iowa Code section 514B.12 of the ratio of full-time equivalent physicians, paramedical and ancillary health personnel to enrollees and fee-for-service patients. Changes in the physician ratios shall be immediately reported together with action taken to correct any deficiencies in the ratios.

40.5(3) Provide assurance that all physicians, paramedical and ancillary health personnel engaged in the provisions of health services to enrollees and fee-for-service patients are currently licensed or certified by the appropriate state agency where they are located to practice their respective profession. These personnel shall be no less qualified in their respective profession than the current level of qualification, which is maintained in their community.

40.5(4) When health care facilities are utilized by the health maintenance organization, these facilities shall be licensed by the appropriate state agency where they are located. These facilities shall be either accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association; or they shall be certified as a provider for Medicare or Medicaid.

40.5(5) Have a qualified administrator designated by the governing body who shall be responsible for the management of the HMO.

40.5(6) Have a formally organized medical staff.

40.5(7) Have a chief of the medical staff designated by the governing body who shall be responsible for the development of medical staff bylaws, rules which shall include assurance to enrollees that a continuum of health care services will be provided without unreasonable periods of delay.

40.5(8) Provide for an ongoing internal peer review program.

40.5(9) Each HMO shall provide a continuous program of general health education for disease prevention and identification without additional cost to the enrollee. Such a program may include publications, media presentations, and classroom instruction. Programs of wellness education including stress management, smoking cessation, nutritional education, physical fitness programs, and other such

programs as approved by the division of insurance shall be open to all enrollees on a voluntary basis and may be subject to a copayment requirement. These programs shall be conducted by qualified personnel.

The HMO must periodically remind and encourage the enrollees of an HMO to utilize benefits including physical examinations which are available and designed to prevent illness. The HMO must also offer periodic screening programs which in the opinion of the medical staff would effectively identify conditions indicative of a health problem. These periodic screening programs shall not carry a copayment. Each HMO shall keep a record of all activities it has conducted to satisfy this requirement and the cost thereof.

40.5(10) Maintain a medical records system which includes at a minimum the following information:

- a. Documentation of utilization rates for every enrollee.
- b. Patient's name, identification number, age, sex, and place of residence and employment.
- c. Services provided, when provided, where provided, and by whom.
- d. Medical diagnosis, treatment prescribed, therapy prescribed and drugs administered.
- e. Statement in regard to the status of the patient's health.

40.5(11) Provide by contract or other arrangement for peer reviews. The plans for internal and external peer review shall be submitted to the commissioner of insurance for approval.

a. Internal peer review shall be conducted by the HMO staff on a continuing basis using Joint Commission on Accreditation of Hospitals, American Osteopathic Association, or American Dental Association, if appropriate, standards as a general guide and shall be structured to review the total episode of illness that the HMO is responsible for. The HMO staff may use parts of the total episode of illness peer review done by other internal review committees to avoid duplication of work. This review shall include but not be limited to the following:

- (1) Utilization review and evaluation of the quality of care provided enrollees.
- (2) The process or method by which care is given.
- (3) The outcome of care including the morbidity and mortality rates that result.

b. External review—criteria and methodology for the selection of an external review group (ERG):

(1) Application to be the ERG may be made in the form of a letter to the commissioner of insurance, describing the qualifications of the ERG and how the ERG meets the criteria set forth in this rule.

(2) Deleted per agency memo, 9/29/93 IAC.

(3) The commissioner shall invite an application from any ERG upon the request of any HMO.

(4) The commissioner may also invite applications from any group which might have the capability of carrying out a review.

(5) The commissioner will consider all applications and appoint one, based on the following criteria:

1. The group's experience in evaluating the quality of medical care.
2. The degree to which the group is representative of the licensed physician community in Iowa.
3. The degree to which the group is knowledgeable about the health delivery system in Iowa.
4. The degree to which selection of the group will avoid duplication with other review activities in Iowa.

5. The group's ability to coordinate its activities with other review groups, and with practitioners and providers of health care in Iowa.

6. The group's knowledge of current and accepted medical opinion, and its ability to make qualitative evaluations of clinical practice.

7. The degree to which at least 50 percent of the physician members of the group (or that part of the group responsible for HMO inspections) are members of an HMO medical staff.

(6) No physician shall review an HMO of which the physician is a member.

(7) Appointment of an ERG will be for a four-year period, and only one ERG will be appointed at a time. Applications for appointment or reappointment will be accepted between 180 days and 90 days before the expiration of the acting ERG's four-year term.

c. External review—criteria and methodology by which an ERG will evaluate the effectiveness of an HMO's peer review program:

(1) The ERG will conduct an on-site inspection of each Iowa-certified HMO every two years, or on a schedule requested by the health department.

(2) The inspection will consist of interviewing HMO staff and physicians, and a review of such records (including clinical records of HMO patients) the ERG determines are necessary to conduct its inspection. The records may include any records or parts thereof maintained by the HMO or any of its physician members which pertain to HMO quality assurance operations or HMO patients, excluding financial records.

(3) The function of the ERG will be to make a qualitative evaluation of the effectiveness of an HMO's internal peer review program, and to report its findings to the health department.

(4) The following items will be considered by the ERG in making its determination:

1. The extent and acuity of the HMO's peer review program in evaluating the clinical management of enrollees provided by HMO physicians.

2. The ability of the HMO's program to identify aberrant practices in clinical management, and to take appropriate disciplinary action

3. The method within the HMO by which the peer review program reports its findings to the medical staff and the governing body.

4. The authority with the HMO to correct practices which the peer review program has found to be detrimental.

5. The system developed within the HMO to facilitate the work of the peer review program.

6. The commitment on the part of the HMO governing body and medical staff toward an active peer review program with a goal of quality assurance.

d. External review—procedures to be followed upon completion of an ERG's inspection:

(1) Within 30 days of the completion of its inspection, the ERG will submit a written report of its findings to the HMO.

(2) The HMO will have 45 days to respond to the ERG.

(3) The ERG must file its final report with the insurance division within 90 days of the completion of its inspection. The final report must include any comments received from the HMO.

(4) The insurance division may extend the time periods referred to in this paragraph "*d.*" subparagraphs (1) to (3).

(5) After considering the report of the ERG, the insurance commissioner shall determine if the HMO's certificate of authority is to be either continued, suspended or revoked.

This rule is intended to implement Iowa Code section 514B.4.

191—40.6(514B) Change of name. No name other than that certified by the division may be used. The name of the HMO may not be changed without prior approval of the division.

191—40.7(514B) Change of ownership. Each HMO which desires to transfer ownership of more than 10 percent of the stock or ownership interest in the HMO shall not do so without first submitting a proposed plan to the division for review and approval or disapproval.

191—40.8(514B) Termination of services. When an HMO desires to cease offering a service, such service may not be terminated without prior approval of the division. Arrangements equitable to the enrollees providing for a rate adjustment or substitution of an equivalent service satisfactory to the division must be made.

191—40.9(514B) Complaints.

40.9(1) Each health maintenance organization shall provide in its bylaws for a system to resolve and record complaints.

40.9(2) The complaint system shall provide for the resolution of the following kinds of complaints and the recording of the information required to be reported to the commissioner:

a. Complaints about the quality of health care services provided by the health maintenance organization.

- b.* Complaints about the availability of such services.
- c.* Complaints relating to enrollee participation in the operation of the health maintenance organization.

40.9(3) The complaint system shall provide for the recording of the information required to be reported to the commissioner relative to the following kinds of complaints:

a. Complaints to the health maintenance organization concerning benefits provided by other than the health maintenance organization under the provisions of any indemnity policy or contract provided by the health maintenance organization. Such complaints shall be referred to the person providing the benefits and a copy shall be forwarded to the commissioner.

b. Malpractice claims settled during the year by the health maintenance organization and any of its providers.

40.9(4) The information required to be reported to the commissioner shall be included in the annual report to the commissioner on the form provided therewith.

40.9(5) All complaint files shall be retained by the health maintenance organization until the examination for the period during which the complaint was received has been completed.

191—40.10(514B) Cancellation of enrollees.

40.10(1) Membership of an enrollee in a health maintenance organization may be terminated by the health maintenance organization for the following reasons and no other:

- a.* Nonpayment of charges when due.
- b.* Termination of the conditions, other than a change in the health of the enrollee, under which the enrollee became eligible to be enrolled under a group contract.
- c.* Termination of the group contract under which the enrollee was enrolled.
- d.* Change of place of residence of the enrollee from the geographic area served by the health maintenance organization.
- e.* Failure of the enrollee to pay deductible or coinsurance charges permitted under Iowa Code section 514B.5(1)“c.”
- f.* Unreasonable refusal of the enrollee to follow a prescribed course of treatment.
- g.* A materially false statement or misrepresentation by the enrollee in an application for membership or benefits.

40.10(2) When membership of an enrollee is terminated by the HMO for a reason other than nonpayment of charges, nonpayment of deductible or coinsurance charges, unreasonable refusal of the enrollee to accept services, or a materially false statement or misrepresentation by the enrollee in the application for membership, the HMO shall arrange to have offered to the enrollee an opportunity to have issued to the enrollee, at the expense of the enrollee, without evidence of insurability, individual or family policy or policies of hospital and medical expense insurance, or individual or family contracts with hospital and medical service corporations. The form of such policies or contracts shall be that shown in the Application for Certificate of Authority of the HMO or the latest approved amendment thereto. The conversion policy or contract shall provide coverage substantially similar to that provided by the HMO. The conversion policy or contract shall also provide at least \$250,000 lifetime benefits. If the HMO enrolls persons on other than a group basis, it shall also offer to the enrollee, if the enrollment was canceled for the reason stated in 40.10(1)“b” or 40.10(1)“c,” an option to be enrolled as an individual enrollee. In the event of insolvency of an HMO and revocation of its certificate of authority, all other HMOs shall offer enrollees of the insolvent HMO an open enrollment period of 30 days after the date of revocation of the certificate.

40.10(3) Membership of an enrollee in a health maintenance organization may be terminated only upon giving a notice of cancellation not less than 30 days before the date of termination. Such notice shall:

- a.* Be given by delivery of the notice in duplicate to the enrollee in person or by certified mail addressed to the enrollee at the last address known to the health maintenance organization.
- b.* State the date and hour upon which the enrollment shall terminate.
- c.* State the reason for cancellation.

d. If cancellation is for nonpayment of charges, state the amount of charges due, the cost of preparing and serving the notice, and the total cost of charges and preparing the notice, and that if the enrollee pays the amount of charges due plus the cost of preparing and serving the notice at any time before the cancellation date the coverage will remain in force.

e. State that the enrollee has the right to a hearing before the commissioner if requested by the enrollee within 20 days after receipt of notice of cancellation.

f. Provide for the enrollee to indicate on the notice that the enrollee requests such hearing.

g. If the enrollee is entitled to have policies or contracts issued as provided in 40.10(2), it shall be stated how the enrollee may apply for such policies or contracts.

h. State that the enrollee may request such hearing by forwarding one copy of the notice of cancellation, marked to request a hearing, to the Commissioner of Insurance, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315.

40.10(4) When a hearing is requested, the commissioner may require the HMO to continue to provide coverage during the pendency of the hearing and a period of not more than ten days after the decision is made known. The commissioner may require the enrollee, as a condition of granting continued coverage, to pay the HMO the charges for such period of coverage.

40.10(5) The hearing shall be held before the commissioner or the delegated hearing officer in the following manner:

a. Upon receipt of a request for hearing, the commissioner shall notify the health maintenance organization and the enrollee of the time and place of hearing.

b. Formal rules of evidence need not be observed, but no evidence shall be received which does not relate to the issue.

c. The burden of proof shall be upon the health maintenance organization to show by a preponderance of the evidence that it had good cause for cancellation for one or more of the reasons stated in the notice and provided herein, except that when the cancellation is for nonpayment of charges, the burden of proof shall be upon the enrollee to show a tender of payment before the date of cancellation.

d. At the close of the hearing, or as soon thereafter as possible, the commissioner shall advise the parties of the commissioner's decision.

This rule is intended to implement Iowa Code section 514B.17.

[ARC 1999C, IAB 5/27/15, effective 7/1/15; Editorial change: IAC Supplement 9/23/20; ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—40.11(514B) Application for certificate of authority. The application for certificate of authority shall be in the following form:

HEALTH MAINTENANCE ORGANIZATION
APPLICATION FOR CERTIFICATE OF AUTHORITY

(Name of Health Maintenance Organization)

Organized as _____
under the laws of the state of _____, hereby makes application to the commissioner of insurance for a certificate of authority to establish and operate a health maintenance organization in compliance with Iowa Code chapter 514B.

Attached hereto and hereby made a part of this application are exhibits bearing numbers corresponding to the following:

1. A copy of the basic organizational document, of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all of its amendments.

2. A copy of the bylaws, rules or similar document, regulating the conduct of the internal affairs of the applicant.

3. A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers if a corporation and the partners or members if a partnership or association.

3.1 A list of the names and addresses of each owner of 5 percent or more of the health maintenance organization.

4. A copy of any contract made or to be made between any providers and the applicant

4.1 A copy of any contract made or to be made between the applicant and any person listed in item (3).

4.2 A copy of any contract made or to be made between the applicant and any person for management services.

5. A statement generally describing the health maintenance organization including, but not limited to, a description of its facilities and personnel.

6. A copy of the form of evidence of coverage.

7. A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees or other organizations.

8. Financial statements showing the applicant’s assets, liabilities, and sources of financial support. If the applicant’s financial affairs are audited by an independent certified public accountant, a copy of the applicant’s most recent regular certified financial statement is attached.

8.1 A copy of any contract made or to be made between the applicant and its reinsurer.

8.2 A copy of any contract made or to be made between the applicant and any person for cash or asset management services.

9. A description of the proposed method of marketing the plan, a financial plan which includes a three-year projection of operating results anticipated, and a statement as to the sources of funding.

10. A power of attorney executed by the applicant, if not domiciled in this state, appointing the commissioner, his successors in office and deputies as the true and lawful attorney of the applicant for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served.

11. A statement reasonably describing the geographic area to be served and assessing in detail the economic feasibility of the HMO’s projected operation.

12. A description of the complaint procedures to be utilized as required under Iowa Code section 514B.14.

13. A description of the procedures and programs to be implemented to meet the requirements for quality of health care as determined by the commissioner of insurance in consideration, when deemed appropriate, with the director of public health, under Iowa Code section 514B.4.

14. A description of the mechanism by which enrollees shall be allowed to participate in matters of policy and operation as required by Iowa Code section 514B.7.

14.1 A copy of the notice to be given to enrollees of the procedure for nomination and election of members of the governing body.

15. A schedule of the liability and workmen’s compensation insurance to be maintained in force by the health maintenance organization.

15.1 Copies of the forms of policies or contracts to be offered to terminated enrollees as provided in 40.10(2).

VERIFICATION

The undersigned deposes and says that deponent has duly executed the attached application dated _____, 20 _____, for and on behalf of _____;

(Name of Applicant)

that deponent is the _____ of such company,

(Title of Officer)

and that deponent is authorized to execute and file such instrument. Deponent further says that deponent is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of deponent's knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

Subscribed and sworn to before me by _____ on
this _____ day of _____, 20 _____.

(Notary Public)

191—40.12(514B) Net worth.

40.12(1) An HMO shall not be authorized to transact business with a net worth less than \$1 million.

40.12(2) No HMO incorporated by or organized under the laws of any other state or government shall transact business in this state unless it possesses the net worth required of an HMO organized by the laws of this state and is authorized to do business in this state.

40.12(3) As deemed necessary by the division, each health maintenance organization that is a subsidiary of another person shall file with the division, in a form satisfactory to it, a guarantee of the HMO's obligations issued by the ultimate controlling parent or such other person satisfactory to the division.

40.12(4) Each health maintenance organization shall, at the time of application, pay to the division a one-time, nonrefundable fee of \$10,000 to be used by the division to create a special fund solely for the payment of administrative expenses in connection with the solvency of an HMO.

191—40.13(514B) Fidelity bond. A health maintenance organization shall maintain in force a fidelity bond on employees and officers in an amount not less than \$100,000 or such other sum as may be prescribed by the commissioner. All such bonds shall be written with at least a one-year discovery period and if written with less than a three-year discovery period shall contain a provision that no cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of 90 days after written notice of cancellation or termination has been filed with the commissioner unless an earlier date of cancellation or termination is approved by the commissioner.

This rule is intended to implement Iowa Code section 514B.5(1).

191—40.14(514B) Annual report. A health maintenance organization shall annually, on or before the first day of March, file with the commissioner of insurance a report verified by at least two of its principal officers and covering the preceding calendar year.

The report shall be on the form designated by the National Association of Insurance Commissioners (NAIC) as the report form for health maintenance organizations. The report shall be completed using "statutory accounting practices" (SAP), and shall include any other information required under law or rule.

The commissioner of insurance may request additional reports and information from a health maintenance organization as often as is deemed necessary to enable the commissioner to carry out the duties of Iowa Code chapter 514B.

This rule is intended to implement Iowa Code section 514B.12.

191—40.15(514B) Cash or asset management agreements. If an HMO utilizes a cash or asset management arrangement with its parent, affiliate, or any other person, the arrangement shall be written and subject to prior approval by the commissioner. Cash or asset management agreements shall meet the following minimum requirements:

40.15(1) Cash receipts shall be under the direct control of the HMO that generated the receipts. If the system is under the control of the HMO's parent or affiliate, then receipts shall be transferred to the HMO within five working days.

40.15(2) Securities purchased shall be in the name of the HMO generating the funds for the security purchase.

40.15(3) An HMO's investments shall not be pooled with other entities' investments unless there is an agreement which vests an undivided interest in the pooled arrangement to the HMO. Such an agreement shall be subject to prior approval by the commissioner.

40.15(4) An HMO's cash or investments shall not be commingled with the cash or investments of any other person.

40.15(5) Investments made on behalf of an HMO shall be subject to the limitations imposed by Iowa Code sections 511.8 and 514B.15.

40.15(6) The agreement shall provide for prompt notice and verification of investments, establish responsibility for brokerage and other fees and provide for periodic reports on earnings and expenses.

40.15(7) A parent, affiliate, person, and employees thereof providing cash or asset management services shall be bonded and responsible for any physical loss of investments.

191—40.16(514B) Deductibles and coinsurance charges. Rescinded IAB 10/15/03, effective 11/19/03.

191—40.17(514B) Reinsurance. Reinsurance contracts and stop-loss agreements entered into by an HMO shall be subject to prior approval and shall meet the following minimum requirements:

40.17(1) Reinsurance contracts and stop-loss agreements shall provide that the commissioner of insurance be given notice of termination by certified mail at least 30 days prior to the effective date of termination of the reinsurance contract or stop-loss agreement.

40.17(2) Retention levels shall be reasonable in light of the HMO's financial condition and potential liabilities.

191—40.18(514B) Provider contracts. An HMO's arrangements for health care services shall be by written contract. Initial provider contracts shall be subject to prior approval. Thereafter, any provider contract deviating from previously submitted or approved contracts shall be submitted to the division within 30 days of execution for informational purposes. In all instances, all provider contracts shall include the following provision:

(Provider), or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to nonpayment by the HMO, HMO insolvency or breach of this agreement, shall (Provider), or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against subscriber/enrollee or persons other than the HMO acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on HMO's behalf made in accordance with terms of (applicable Agreement) between HMO and subscriber/enrollee.

(Provider), or its assignee or subcontractor, further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the HMO subscriber/enrollee and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (Provider) and subscriber/enrollee or persons acting on their behalf.

191—40.19(514B) Producers' duties. In order to qualify for solicitation, enrollment, or delivery of a certificate of membership or policy in a health maintenance organization, a producer must comply with the licensing rules set forth in 191—Chapter 10 and in particular pass the accident and health or sickness insurance lines of authority examination.

[ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—40.20(514B) Emergency services. Benefits shall be available by the HMO for inpatient and outpatient emergency services. A physician and sufficient other licensed and ancillary personnel shall be readily available at all times to render such services. Since HMOs may not contract with every emergency care provider in an area, HMOs shall make every effort to inform members of participating providers.

40.20(1) The term “emergency services” means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition.

40.20(2) The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention to result in one of the following:

- a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;
- b. Serious impairment to bodily function; or
- c. Serious dysfunction of any bodily organ or part.

191—40.21(514B) Reimbursement. Reimbursement to a provider of “emergency services,” as defined in 191—40.1(514B), shall not be denied by any health maintenance organization without that organization’s review of the patient’s medical history, presenting symptoms, and admitting or initial as well as final diagnosis, submitted by the provider, in determining whether, by definition, emergency services could reasonably have been expected to be provided. Reimbursement for emergency services shall not be denied solely on the grounds that services were performed by a noncontracted provider. If reimbursement for emergency services is denied, the enrollee may file a complaint with the HMO as outlined in rule 191—40.9(514B). Upon denial of reimbursement for emergency services, the HMO shall notify the enrollee and the provider that they may register a complaint with the commissioner of insurance.

191—40.22(514B) Health maintenance organization requirements.

40.22(1) A health maintenance organization shall not prohibit a participating provider from or penalize a participating provider for discussing treatment options with covered persons, irrespective of the health maintenance organization’s position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the health maintenance organization or a person contracting with the health maintenance organization.

40.22(2) A health maintenance organization shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health maintenance organization that, in the opinion of the provider, jeopardizes patient health or welfare.

191—40.23(514B) Disclosure requirements. All HMOs shall include in contracts and evidence of coverage forms a statement disclosing the existence of any prescription drug formularies. Upon request, an HMO offering a plan that includes a prescription drug formulary shall inform enrollees of the plan, and prospective enrollees of the plan during any open enrollment period, whether a prescription drug specified in the request is included in such formulary.

All HMOs shall also disclose the existence of any contractual arrangements providing rebates received by them for prescription drugs or durable medical equipment. Durable medical equipment means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose and is generally not useful to a person who is not sick or injured or used by other family members and is appropriate for home use for the purpose of improving bodily functions or preventing further deterioration of the medical condition caused by sickness or injury.

191—40.24(514B) Provider access. A health maintenance organization shall allow a female enrollee direct access to obstetrical and gynecological services from network or participating providers. The plan shall also allow a pediatrician to be the primary care provider for a child through the age of 18.

191—40.25(514B) Electronic delivery of accident and health group insurance certificates.

40.25(1) Purpose. The purpose of this rule is to authorize the electronic delivery of accident and health group insurance certificates in an efficient manner by health maintenance organizations and group policyholders, while guaranteeing that individual plan members still receive the important information contained in such group insurance certificates, as required by Iowa Code section 514B.9 and as allowed by the uniform electronic transactions Act, Iowa Code chapter 554D.

40.25(2) Scope. This rule shall apply to all health maintenance organizations holding a certificate of authority to transact the business of insurance under the provisions of Iowa Code chapter 514B.

40.25(3) Electronic delivery—health maintenance organizations. The health maintenance organization will be deemed to comply with the requirements of Iowa Code section 514B.9 if the group insurance certificate is delivered to the group policyholder electronically and if:

a. The health maintenance organization takes appropriate and necessary measures to ensure that the system for furnishing group insurance certificates results in actual receipt of transmitted information by group policyholders, which may be done by:

- (1) Using return-receipt electronic mail features;
- (2) Periodic reviews or surveys to confirm receipt of the transmitted information; or
- (3) Any other method approved by the insurance commissioner.

b. The electronic documents contain the same content and appear in reasonably the same format as the certificates previously approved by the insurance commissioner.

c. Each group policyholder is provided notice, through electronic means or in writing, apprising the group policyholder of the fact that the certificate will be furnished electronically, of the significance of the certificate and the group policyholder's obligations under this rule, and of the group policyholder's right to request and receive a paper copy of the document for each participant.

d. Upon request of any group policyholder, the health maintenance organization furnishes paper copies of the group insurance certificate that was delivered to the group policyholder electronically, so that the group policyholder may provide them to participants that have requested paper copies.

40.25(4) Electronic delivery—group policyholders. The group policyholder will be deemed to comply with the requirements of Iowa Code section 514B.9 if the group insurance certificate is delivered to the individual plan member electronically and if:

a. The group policyholder takes appropriate and necessary measures to ensure that the system for furnishing group insurance certificates results in actual receipt of transmitted information by participants, which may be done by:

- (1) Using return-receipt electronic mail features;
- (2) Periodic reviews or surveys to confirm receipt of the transmitted information; or
- (3) Any other method approved by the insurance commissioner.

b. The electronic documents contain the same content and appear in reasonably the same format as the certificates previously approved by the insurance commissioner.

c. Each participant is provided notice, through electronic means or in writing, apprising the participant of the fact that the certificate will be furnished electronically, of the significance of the certificate, and of the participant's right to request and receive, free of charge, a paper copy of the document.

d. Upon request of any participant, the group policyholder furnishes, free of charge, a paper copy of the group insurance certificate that was delivered to the participant electronically.

This rule is intended to implement Iowa Code chapter 514B.

191—40.26(514B) Notice of cancellation, nonrenewal or termination of enrollment.

40.26(1) Purpose and definitions.

a. Purpose. The purpose of this rule is to clarify the authorized methods of delivery for notices of cancellation, nonrenewal or termination by a health maintenance organization, so as to implement the various consumer protections intended by Iowa Code sections 514B.17 and 514B.17A and rule 191—40.10(514B).

b. Definitions. As used in Iowa Code section 505B.1 and this rule:

“*Commissioner*” means the Iowa insurance commissioner or insurance division.

“*Notice of cancellation, nonrenewal or termination*” means:

1. Notice of an insurance company’s termination of an insurance policy at the end of a term or before the termination date;

2. Notice of an insurance company’s decision or intention not to renew a policy; and

3. For purposes of notices required by Iowa Code sections 514B.17 and 514B.17A and rule 191—40.10(514B), “notice of cancellation, nonrenewal or termination” includes but is not limited to a health maintenance organization’s notice to an enrollee of cancellation or rescission of membership.

40.26(2) Scope. This rule shall apply to all insurance companies holding a certificate of authority to operate an HMO under the provisions of Iowa Code chapter 514B.

40.26(3) Delivery. For any notice of cancellation, nonrenewal or termination by a health maintenance organization under Iowa Code sections 514B.17 and 514B.17A and rule 191—40.10(514B) to be effective, a health maintenance organization must, within the time frame established by law, deliver the notice to the person to whom notice is required to be provided either in person or by mail through the U.S. Postal Service to the last-known address of the person to whom notice is required to be provided. The use of U.S. Postal Service Intelligent Mail® fulfills any requirement in Iowa Code sections 514B.17 and 514B.17A and rule 191—40.10(514B) for certified mail or certificate of mailing as proof of mailing.

40.26(4) Electronic transmissions. Notwithstanding the requirements of subrule 40.26(3), if an insurer receives, pursuant to 191—subrule 4.24(2), approval from the commissioner of a manner of electronic delivery of a notice of cancellation, nonrenewal or termination of a policy, the approved manner shall satisfy the notice requirements of Iowa Code sections 514B.17 and 514B.17A and rule 191—40.10(514B).

This rule is intended to implement Iowa Code chapter 505B.

[ARC 1999C, IAB 5/27/15, effective 7/1/15; ARC 2415C, IAB 2/17/16, effective 3/23/16]

These rules are intended to implement Iowa Code chapters 514B, 514C, 514F, 514J and 514K.

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CHAPTER 41
LIMITED SERVICE ORGANIZATIONS

191—41.1(514B) Definitions.

“*Act*” when used in these rules shall mean Iowa Code chapter 514B.

“*Complaint*” means a written communication expressing a grievance concerning a limited service organization.

“*Governing body*” means the persons in which the ultimate responsibility and authority for the conduct of the LSO is vested.

“*Limited health services*” include dental care services, vision care services, mental health services, behavioral health care services, substance abuse services, pharmaceutical services, podiatric care services, chiropractic services, nursing services, services of a licensed dietitian, physical therapy services, or any other category of services approved by the commissioner. “Limited health services” do not include employee assistance programs which provide only assessment and referral services or intermediate or long-term care facilities.

“*Limited service organization*” or “*LSO*” means any corporation or limited liability company or other entity which, in return for prepayment, undertakes to provide or arrange for the provision of one or more limited health services to enrollees. Entities authorized to do business pursuant to Iowa Code chapters 508, 512B, 514, 514B (health maintenance organizations), 515, and 520 shall not be required to obtain separate licensure as an LSO.

“*Outpatient provider services*” means outpatient provider services provided within or outside of a hospital. These services shall include, but not be limited to, laboratory and diagnostic X-ray with emphasis directed toward primary care.

“*Producer*” means a person engaged in solicitation or enrollment for an LSO and who ultimately delivers the certificate of membership or policy to a member.

“*Provider*” means any person or institution duly licensed or otherwise authorized to deliver or furnish limited health services.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

191—41.2(514B) Application. An application on forms provided by the insurance division accompanied by a filing fee of \$100 payable to State Treasurer, State of Iowa, shall be completed by an officer or authorized representative of the LSO. The application with copies in duplicate shall be executed in conformance with rule 191—41.10(514B) and shall be accompanied by the information found in Iowa Code section 514B.3(1). An application shall not be deemed to be filed until all information necessary to properly process said application has been received by the commissioner, as indicated in rule 191—41.10(514B). Amendments to the application form shall be filed in the same manner as the application and approved by the commissioner before the change proposed by the amendment is effective.

[ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—41.3(514B) Inspection of evidence of coverage. Except for groups which maintain a cafeteria plan pursuant to Section 125 of the Internal Revenue Code (28 U.S.C.A. § 125), an enrollee may, if evidence of coverage is not satisfactory for any reason, return evidence of coverage within ten days of receipt of same and receive full refund of the deposit paid, if any. This right shall not act as a cure for misleading or deceptive advertising or marketing methods, nor may it be exercised if the enrollee utilizes the services of the LSO within the ten-day period. Enrollees in cafeteria plans must adhere to the plan provisions concerning termination or changes in coverage.

191—41.4(514B) Governing body and enrollee representation. An LSO shall have a basic written organizational document setting forth its scheme of organization and establishing a governing body appropriate to its form of organization. The governing body shall be responsible for matters of policy and operation.

The LSO shall develop bylaws or guidelines which describe the scope of the health care services the LSO renders to enrollees directly by a provider. Initial articles of incorporation, bylaws, guidelines of the LSO and revisions thereto shall be submitted to the commissioner of insurance for review and approval.

The articles of incorporation, bylaws, guidelines, or similar document shall provide for “reasonable representation” on the governing body by enrollees. “Reasonable representation” as used in Iowa Code section 514B.7 shall require that not less than 30 percent of the governing board members be enrollees who are not providers or are not associated with a provider. Enrollees shall have the opportunity to nominate said enrollee representatives.

The LSO may provide upon its initial formation that all representatives on the governing board shall be selected by the organizers of the LSO. Such members shall serve until the first annual meeting or election. If there are no enrollee representatives on the initial governing board, they shall be elected at the first annual meeting or election. The nomination procedures for enrollee representatives should provide for the following to ensure an adequate opportunity for participation by enrollees:

41.4(1) An opportunity for adult enrollees to nominate candidates for the governing body.

41.4(2) Notice to all adult enrollees of the nomination and elective procedures. The LSO shall be deemed to have complied with these requirements if it provides notice in its regular newsletter to enrollees of the opportunity to and the procedures for nomination of enrollee representatives. Nomination procedures may be waived by the commissioner for a period of up to three years from the LSO’s commencement of delivery of services to enrollees.

191—41.5(514B) Quality of care. Each LSO shall:

41.5(1) Advise the insurance division annually of the ratio of full-time providers and ancillary health personnel to enrollees to ensure an adequate network. Changes in the provider ratios shall be immediately reported together with action taken to correct any deficiencies in the ratios.

41.5(2) Provide assurance that all personnel engaged in the provision of health services to enrollees are currently licensed or certified by the appropriate state agency where the providers are located to practice their respective professions. These personnel shall be no less qualified in their respective professions than the current level of qualification, which is maintained in the providers’ communities.

41.5(3) Provide assurance that any health care facilities utilized by the LSO are licensed by the appropriate state agency where the facilities are located. These facilities shall be accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association; or they shall be certified as a provider for Medicare or Medicaid; or as otherwise accredited or licensed in accordance with state or federal law.

41.5(4) Have a qualified administrator designated by the governing body who shall be responsible for the management of the LSO.

41.5(5) Provide for an ongoing internal peer review program.

41.5(6) Maintain a provider records system which includes at a minimum the following information:

a. Documentation of utilization rates for every enrollee.

b. Patient’s name, identification number, age, sex, and place of residence, and place of employment, if applicable.

c. Services provided, when provided, where provided, and by whom.

d. Provider diagnosis, treatment prescribed, therapy prescribed and drugs administered.

e. Statement in regard to the status of the patient’s health, as appropriate.

41.5(7) Provide by contract or other arrangement for peer review. The plans for internal and external peer review shall be submitted to the commissioner of insurance for approval.

a. Internal peer review shall be conducted by the LSO staff on a continuing basis using standards adopted by the applicable accrediting body as a general guide. Internal peer review shall be structured to review the specific type of services for which the LSO is responsible. This review shall include but not be limited to the following:

(1) Utilization review and evaluation of the quality of services provided enrollees.

(2) The process or method by which services are provided.

- (3) The outcome of services.
 - b. External review may be satisfied either by NCQA certification or meeting the requirements of the external review group appointed by the commissioner. The criteria and methodology for selection of an external review group (ERG) are as follows:
 - (1) The commissioner will appoint an ERG based on the following criteria:
 1. The group's experience in evaluating the quality of service provided.
 2. The degree to which the group is representative of the LSOs to be reviewed.
 3. The degree to which the group is knowledgeable about the delivery of the services provided by the LSO in Iowa.
 4. The group's ability to coordinate its activities with other review groups and with practitioners and providers of health services in Iowa.
 5. The group's knowledge of current and accepted provider opinion and its ability to make qualitative evaluations of clinical practice.
 - (2) No provider shall review an LSO of which the provider is a member.
 - (3) Appointment of an ERG will be for a four-year period, and only one ERG will be appointed at a time. Applications for appointment or reappointment will be accepted between 180 days and 90 days before the expiration of the acting ERG's four-year term.
 - c. The following are criteria and methodology by which an ERG will evaluate the effectiveness of an LSO's peer review program:
 - (1) The ERG will conduct an on-site inspection of each Iowa-certified LSO every two years.
 - (2) The inspection will consist of an interview with LSO staff and providers and a review of records (including clinical records of LSO patients) the ERG determines are necessary to conduct its inspection. The records may include any records or parts thereof maintained by the LSO or any of its provider members which pertain to LSO quality assurance operations or LSO patients, excluding financial records.
 - (3) The function of the ERG will be to make a qualitative evaluation of the effectiveness of an LSO's internal peer review program and to report its findings to the insurance division.
 - (4) The following items will be considered by the ERG in making its determination:
 1. The extent and acuity of the LSO's peer review program in evaluating the clinical management of enrollees provided by LSO providers.
 2. The ability of the LSO's program to identify aberrant practices in clinical management and to take appropriate disciplinary action.
 3. The method within the LSO by which the peer review program reports its findings to the provider staff and the governing body.
 4. The authority within the LSO to correct practices which the peer review program has found to be detrimental.
 5. The system developed within the LSO to facilitate the work of the peer review program.
 6. The commitment on the part of the LSO governing body and provider staff toward an active peer review program with a goal of quality assurance.
 - d. The following are procedures to be followed upon completion of an ERG's inspection:
 - (1) Within 30 days of the completion of its inspection, the ERG will submit a written report of its findings to the LSO.
 - (2) The LSO will have 45 days to respond to the ERG.
 - (3) The ERG must file its final report with the insurance division within 90 days of the completion of its inspection. The final report must include any comments received from the LSO.
 - (4) The insurance division may extend the time periods referred to in subparagraphs 41.5(7) "d"(1) to (3).
 - (5) After considering the report of the ERG, the insurance commissioner shall determine if the LSO's certificate of authority is to be continued, suspended or revoked.

191—41.6(514B) Change of name. No name other than that certified by the division may be used. The name of the LSO may not be changed without prior approval of the division.

191—41.7(514B) Change of ownership. Each LSO which desires to transfer ownership of more than 10 percent of the stock or ownership interest in the LSO shall not do so without first submitting a proposed plan to the division for review and approval or disapproval.

191—41.8(514B) Complaints.

41.8(1) Each LSO shall provide in its bylaws for a system to resolve and record complaints.

41.8(2) The complaint system shall provide for the resolution of the following kinds of complaints and the recording of the information required to be reported to the commissioner.

- a.* Complaints about the quality of health care services provided by the LSO.
- b.* Complaints about the availability of such services.
- c.* Complaints relating to enrollee participation in the operation of the LSO.

41.8(3) The complaints record shall be included in the annual report to the commissioner.

41.8(4) All complaint files shall be retained by the LSO until the examination for the period during which the complaint was received has been completed.

191—41.9(514B) Cancellation of enrollees.

41.9(1) Membership of an enrollee in an LSO may be terminated by the LSO for the following reasons and no other:

- a.* Nonpayment of charges when due.
- b.* Termination of the conditions, other than a change in the health of the enrollee, under which the enrollee became eligible to be enrolled under a group contract.
- c.* Termination of the group contract under which the enrollee was enrolled.
- d.* Change of place of residence of the enrollee from the geographic area served by the LSO.
- e.* Failure of the enrollee to pay deductible or coinsurance charges permitted under Iowa Code section 514B.5(1)“c.”
- f.* Unreasonable refusal of the enrollee to follow a prescribed course of treatment.
- g.* A materially false statement or misrepresentation by the enrollee in an application for membership or benefits.
- h.* Withdrawal of licensure by the LSO from the state. Upon withdrawal, an LSO has no obligation to secure replacement coverage for enrollees.

41.9(2) Membership of an enrollee in an LSO may be terminated only upon giving a notice of cancellation not less than 30 days before the date of termination. Such notice shall:

- a.* Be given by delivery of the notice in duplicate to the enrollee in person or by certified mail addressed to the enrollee at the last address known to the LSO.
- b.* State the date and hour upon which the enrollment shall terminate.
- c.* State the reason for cancellation.
- d.* If cancellation is for nonpayment of charges, state the amount of charges due, the cost of preparing and serving the notice, and the total cost of charges and preparing the notice, and that if the enrollee pays the amount of charges due plus the cost of preparing and serving the notice at any time before the cancellation date, the coverage will remain in force.
- e.* State that the enrollee has the right to a hearing before the commissioner if requested by the enrollee within 20 days after receipt of notice of cancellation.
- f.* Provide for the enrollee to indicate on the notice that the enrollee requests such hearing.
- g.* State that the enrollee may request such hearing by forwarding one copy of the notice of cancellation, marked to request a hearing, to the Commissioner of Insurance, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315.

41.9(3) When a hearing is requested, the commissioner may require the LSO to continue to provide coverage during the pendency of the hearing and a period of not more than ten days after the decision is made known. The commissioner may require the enrollee, as a condition of granting continued coverage, to pay the LSO the charges for such period of coverage.

41.9(4) The hearing shall be held before the commissioner or the delegated administrative law judge in the following manner:

a. Upon receipt of a request for hearing, the commissioner shall notify the LSO and the enrollee of the time and place of hearing.

b. Formal rules of evidence need not be observed, but no evidence shall be received which does not relate to the issue.

c. The burden of proof shall be upon the LSO to show by a preponderance of the evidence that it had good cause for cancellation for one or more of the reasons stated in the notice and provided herein, except that when the cancellation is for nonpayment of charges, the burden of proof shall be upon the enrollee to show a tender of payment before the date of cancellation.

d. At the close of the hearing, or as soon thereafter as possible, the commissioner shall advise the parties of the commissioner's decision.

[ARC 4780C, IAB 11/20/19, effective 12/25/19; Editorial change: IAC Supplement 9/23/20; ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—41.10(514B) Application for certificate of authority. The application for certificate of authority shall be in the following form:

LIMITED SERVICE ORGANIZATION
APPLICATION FOR CERTIFICATE OF AUTHORITY
(Name of Limited Service Organization)

Organized as _____ under the laws of the state of _____, makes application to the commissioner of insurance for a certificate of authority to establish and operate a limited service organization in compliance with Iowa Code chapter 514B.

Attached and made a part of this application are exhibits bearing numbers corresponding to the following:

1. A copy of the basic organizational document of the applicant, such as the articles of incorporation, articles of association or other applicable documents and all of its amendments.

2. A copy of the bylaws, rules or similar document regulating the conduct of the internal affairs of the applicant.

3. A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers if a corporation and the partners or members if a partnership or association.

3.1 A list of the names and addresses of each owner of 5 percent or more of the LSO.

4. A copy of any contract made or to be made between any providers and the applicant.

4.1 A copy of any contract made or to be made between the applicant and any person listed in paragraph "3" above.

4.2 A copy of any contract made or to be made between the applicant and any person for management services.

5. A statement generally describing the LSO including, but not limited to, a description of its facilities and personnel.

6. A copy of the form of evidence of coverage.

7. A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees or other organizations.

8. Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by an independent certified public accountant, a copy of the applicant's most recent regular certified financial statement is attached.

8.1 A copy of any contract made or to be made between the applicant and its reinsurer.

8.2 A copy of any contract made or to be made between the applicant and any person for cash or asset management services.

9. A description of the proposed method of marketing the plan, a financial plan which includes a three-year projection of operating results anticipated, and a statement as to the sources of funding.

10. A power of attorney executed by the applicant, if not domiciled in this state, appointing the commissioner, the commissioner's successors in office and deputies as the true and lawful attorney of the applicant for this state upon whom all lawful process in any legal action or proceeding against the LSO on a cause of action arising in this state may be served.

11. A statement reasonably describing the geographic area to be served and assessing in detail the economic feasibility of the LSO's projected operation.

12. A description of the complaint procedures to be utilized as required under Iowa Code section 514B.14.

13. A description of the procedures and programs to be implemented to meet the requirements for quality of health care as determined by the commissioner of insurance under Iowa Code section 514B.4.

14. A description of the mechanism by which enrollees shall be allowed to participate in matters of policy and operation as required by Iowa Code section 514B.7.

14.1 A copy of the notice to be given to enrollees of the procedure for nomination and election of members of the governing body.

15. A schedule of the liability and workers' compensation insurance to be maintained in force by the LSO.

VERIFICATION

The undersigned deposes and states that deponent has duly executed the attached application dated _____, _____, for and on behalf of _____; that
(Year) (Name of Applicant)
the deponent is the _____ of such company, and that deponent is
(Title of Officer)

authorized to execute and file such instrument. Deponent further states that deponent is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of deponent's knowledge, information and belief.

(Signature)

(type or print name beneath)

Subscribed and sworn to before me by _____ on this _____ day of _____,

(Year)

(Notary Public)

191—41.11(514B) Net equity and deposit requirements.

41.11(1) Net equity requirements.

a. Each LSO shall, at all times, have and maintain a tangible net equity at least equal to the greater of:

(1) \$100,000 at the inception of the first year of operation, \$200,000 at the inception of the second year of operation and thereafter; or

(2) Two percent of the organization's annual gross premium income, up to a maximum of the required capital and surplus of an accident and health insurer.

b. An LSO that has uncovered expenses in excess of \$500,000, as reported on the most recent annual financial statement filed with the commissioner, shall maintain tangible net equity equal to 25 percent of the uncovered expense in excess of \$500,000 in addition to the tangible net equity required by paragraph 41.11(1) "a."

c. For the purpose of this rule, "net equity" shall mean the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the commissioner; and "net equity" shall mean net equity reduced by the value assigned to intangible assets, including, but not limited to:

- (1) Goodwill;
- (2) Going-concern value;
- (3) Organizational expense;
- (4) Start-up costs;

(5) Obligations of officers, directors or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with nonaffiliates and which are not past due;

(6) Long-term prepayments of deferred charges; and

(7) Nonreturnable deposits.

41.11(2) Deposits.

a. Each LSO shall deposit with the commissioner or with any organization or trustee meeting the requirements of rule 191—32.4(508) cash, securities or any combination of these that is acceptable to the commissioner having a fair market value equal to the minimum net worth of the LSO as determined by paragraph 41.11(1)“*a.*” The amount on deposit shall remain as an admitted asset of the organization in the determination of its net worth.

b. All income from deposits shall be an asset of the LSO. An LSO may withdraw a deposit or any part thereof, first having deposited, in lieu thereof, a deposit of cash, securities, or any combination of these in an amount and value equal to that to be withdrawn. Securities shall be approved by the commissioner before being substituted.

41.11(3) No LSO organized under the laws of another state shall, directly or indirectly, assume risks or provide the services of an LSO, as defined in Iowa Code section 514B.33, subsection (3), unless it first obtains licensure from the commissioner and complies with the requirements of rule 191—41.11(514B).

41.11(4) As deemed necessary by the division, each LSO that is a subsidiary of another person shall file with the division, in a form satisfactory to the division, a guarantee of the LSO’s obligations issued by the ultimate controlling parent or such other person satisfactory to the division.

41.11(5) Each LSO shall, at the time of application, pay to the division a one-time, nonrefundable fee of \$10,000 to be used by the division to create a special fund solely for the payment of administrative expenses in connection with the insolvency of an LSO.

191—41.12(514B) Fidelity bond. An LSO shall maintain in force a fidelity bond on employees and officers in an amount not less than \$100,000 or such other sum as may be prescribed by the commissioner. All such bonds shall be written with at least a one-year discovery period and if written with less than a three-year discovery period shall contain a provision that no cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of 90 days after written notice of cancellation or termination has been filed with the commissioner unless an earlier date of cancellation or termination is approved by the commissioner.

191—41.13(514B) Annual report. An LSO shall annually, on or before the first day of March, file with the commissioner of insurance a report verified by at least two of its principal officers and covering the preceding calendar year. The report shall be on the form designated by the National Association of Insurance Commissioners (NAIC) as the report form for LSOs. The report shall be completed using statutory accounting practices (SAP), and shall include any other information required under law or rule.

The commissioner of insurance may request additional reports and information from an LSO as often as is deemed necessary to enable the commissioner to carry out the duties of Iowa Code chapter 514B.

191—41.14(514B) Cash or asset management agreements. If an LSO utilizes a cash or asset management arrangement with its parent, affiliate, or any other person, the arrangement shall be written and subject to prior approval by the commissioner. Cash or asset management agreements shall meet the following minimum requirements:

1. Cash receipts shall be under the direct control of the LSO that generated the receipts. If the system is under the control of the LSO’s parent or affiliate, then receipts shall be transferred to the LSO within five working days.

2. Securities purchased shall be in the name of the LSO generating the funds for the security purchase.

3. An LSO's investments shall not be pooled with other entities' investments unless there is an agreement which vests an undivided interest in the pooled arrangement to the LSO. Such an agreement shall be subject to prior approval by the commissioner.

4. An LSO's cash or investments shall not be commingled with the cash or investments of any other person.

5. Investments made on behalf of an LSO shall be subject to the limitations imposed by Iowa Code sections 511.8 and 514B.15.

6. The agreement shall provide for prompt notice and verification of investments, establish responsibility for brokerage and other fees and provide for periodic reports on earnings and expenses.

7. A parent, affiliate, person, and employees thereof providing cash or asset management services shall be bonded and responsible for any physical loss of investments.

191—41.15(514B) Reinsurance. Reinsurance contracts and stop-loss agreements entered into by an LSO shall be subject to prior approval and shall meet the following minimum requirements:

1. Reinsurance contracts and stop-loss agreements shall provide that the commissioner of insurance be given notice of termination by certified mail at least 30 days prior to the effective date of termination of the reinsurance contract or stop-loss agreement.

2. Retention levels shall be reasonable in light of the LSO's financial condition and potential liabilities.

191—41.16(514B) Provider contracts. An LSO's arrangements for health care services shall be by written contract. Initial provider contracts shall be subject to prior approval. Thereafter, any provider contract deviating from previously submitted or approved contracts shall be submitted to the division for approval. In all instances, all provider contracts shall include the following provision:

(Provider), or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to, nonpayment by the LSO, LSO insolvency or breach of this agreement, shall (Provider), or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against subscriber/enrollee or persons other than the LSO acting on the providers' behalf for services provided pursuant to this agreement. This provision shall not prohibit collection of supplemental charges or copayments on LSO's behalf made in accordance with terms of (applicable agreement) between LSO and subscriber/enrollee.

(Provider), or its assignee or subcontractor, further agrees that (1) this provision shall survive the termination of this agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the LSO subscriber/enrollee and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (Provider) and subscriber/enrollee or persons acting on their behalf.

191—41.17(514B) Producers' duties. In order to qualify for solicitation, enrollment, or delivery of a certificate of membership or policy in an LSO, a producer must comply with the licensing rules set forth in 191—Chapter 10 and in particular pass the accident and health or sickness insurance line of authority examination.

[ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—41.18(514B) Emergency services. "Emergency services" (inpatient and outpatient), as defined in rule 191—40.20(514B), shall be provided by the LSO, either through its own facilities or through guaranteed arrangements with other providers, on a 24-hour basis unless a waiver from such services is approved by the commissioner. A provider and sufficient other licensed and ancillary personnel shall be readily available at all times to render such services. Since LSOs may not contract with every emergency care provider in an area, LSOs shall make every effort to inform members of participating providers.

191—41.19(514B) Reimbursement. Reimbursement to a provider of "emergency services," as defined in rule 191— 40.20(514B), shall not be denied by any LSO without that organization's review of the patient's provider history, presenting symptoms, and admitting or initial as well as final diagnosis,

submitted by the provider, in determining whether, by definition, emergency services could reasonably have been expected to be provided. Reimbursement for emergency services shall not be denied solely on the grounds that services were performed by a noncontracted provider. If reimbursement for emergency services is denied, the enrollee may file a complaint with the LSO as outlined in rule 191—40.9(514B). Upon denial of reimbursement for emergency services, the LSO shall notify the enrollee and the provider that they may register a complaint with the commissioner of insurance.

191—41.20(514B) Limited service organization requirements. An LSO shall not prohibit or otherwise restrict a participating provider from advising a covered person about the health status of the covered person or medical care or treatment of the covered person's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the provider is acting within the lawful scope of practice.

An LSO shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the LSO that, in the opinion of the provider, jeopardizes patient health or welfare.

191—41.21(514B) Disclosure requirements. All LSOs shall include in contracts and evidence of coverage forms a statement disclosing the existence of any prescription drug formularies. Upon request, all LSOs offering policies under this chapter that include a prescription drug formulary shall inform policyholders, and prospective policyholders at time of issuance, whether a prescription drug specified in the request is included in such formulary.

All LSOs shall also disclose the existence of any contractual arrangements providing rebates received by them for drugs or durable medical equipment. Durable medical equipment means equipment that can stand repeated uses and is primarily and customarily used to serve a medical purpose and is generally not useful to a person who is not sick or injured or used by other family members and is appropriate for home use for the purpose of improving bodily function or preventing further deterioration of the medical condition caused by sickness or injury.

These rules are intended to implement Iowa Code section 514B.33.

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[Editorial change: IAC Supplement 9/23/20]

[Filed ARC 5515C (Notice ARC 5389C, IAB 1/13/21), IAB 3/10/21, effective 4/14/21]

CHAPTER 44
SMOKER/NONSMOKER MORTALITY TABLES
FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES
AND NONFORFEITURE BENEFITS

191—44.1(508) Purpose. The purpose of the rule is to permit the use of mortality tables that reflect differences in mortality between smokers and nonsmokers in determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits for plans of insurance with separate risk classifications for smokers and nonsmokers.

191—44.2(508) Definitions.

“1980 CSO Table, with or without Ten-Year Select Mortality Factor” means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Valuation Law and Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Standard Ordinary Mortality Table, with or without Ten-Year Select Mortality Factors. The same select factors will be used for both smokers and nonsmokers tables.

“1980 CET Table” means that mortality table consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioners 1980 Extended Term Insurance Table.

“1958 CSO Table” means that mortality table developed by the Society of Actuaries Special Committee on New Mortality Tables, incorporated in the NAIC Model Standard Nonforfeiture Law for Life Insurance, and referred to in that model as the Commissioners 1958 Standard Ordinary Mortality Table.

“1958 CET Table” means that mortality table developed by the Society of Actuaries Special Committee on New Mortality Tables, incorporated in the NAIC Model Standard Nonforfeiture Law for Life Insurance, and referred to in that model as the Commissioners 1958 Extended Term Insurance Table.

“Smoker and nonsmoker mortality tables” means those mortality tables with separate rates of mortality for smokers and nonsmokers derived from the tables defined in the first four paragraphs of this rule which were developed by the Society of Actuaries Task Force on Smoker/Nonsmoker Mortality and the California Insurance Department staff and recommended by the NAIC Technical Staff Actuarial Group.

“Composite mortality tables” means those mortality tables defined in the first four paragraphs of this rule as they were originally published with rates of mortality that do not distinguish between smokers and nonsmokers.

191—44.3(508) Alternate tables.

44.3(1) In determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits for any policy of insurance delivered or issued for delivery in this state after the operative date of Iowa Code section 508.37(7) “k” for that policy form and before January 1, 1989, at the option of the company and subject to the conditions stated in rule 191—44.4(508):

a. The 1958 CSO Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors, and

b. The 1958 CET Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CET Table.

For any category of insurance issued on female lives with minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits determined using the 1958 CSO or 1958 CET Smoker and Nonsmoker Mortality Tables, such minimum values may be calculated according

to an age not more than six years younger than the actual age of the insured. Further, the substitution of the 1958 CSO or 1958 CET Smoker and Nonsmoker Mortality Tables is available only if made for each policy of insurance on a policy form delivered or issued for delivery on or after the operative date for that policy form and before a date not later than January 1, 1989.

44.3(2) In determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits for any policy of insurance delivered or issued for delivery in this state after the operative date of Iowa Code section 508.37(7)“k” for that policy form, at the option of the company and subject to the conditions stated in rule 191—44.4(508):

a. The 1980 CSO Smoker and Nonsmoker Mortality Tables, with or without Ten-Year Select Mortality Factors, may be substituted for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors, and

b. The 1980 CET Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CET Table.

[ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—44.4(508) Conditions. For each plan of insurance with separate rates for smokers and nonsmokers an insurer may:

1. Use composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits,

2. Use smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by Iowa Code section 508.36(3)“a”(1) and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits, or

3. Use smoker and nonsmoker mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

191—44.5(508) Separability. If any provision of this chapter or the application of this chapter to any person or circumstance is for any reason held to be invalid, the remainder of this chapter and the application of the remaining provisions to other persons or circumstances shall not be affected.

191—44.6(508) 2001 CSO Mortality Table. The 2001 CSO Mortality Table shall be used for purposes of this chapter pursuant to the requirements of 191—Chapter 91.

These rules are intended to implement Iowa Code section 508.37(6)“h”(6).

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

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INSURANCE HOLDING COMPANY SYSTEMS

CHAPTER 45

INSURANCE HOLDING COMPANY SYSTEMS

[Appeared as Ch 11, 1973 IDR]

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

191—45.1(521A) Purpose. The purpose of these rules is to set forth rules and procedural requirements which the commissioner deems necessary to carry out the provisions of Iowa Code chapter 521A. The information called for by these rules is hereby declared to be necessary and appropriate in the public interest and for the protection of policyholders in this state.

This rule is intended to implement Iowa Code section 521A.8.

191—45.2(521A) Definitions. In addition to the definitions in Iowa Code section 521A.1 and 191—1.1(502,505), the following rules apply to this chapter, unless otherwise required by the context:

“Executive officer” means any individual charged with active management and control in an executive capacity (including a president, vice-president, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers) of a person, whether incorporated or unincorporated.

“Foreign insurer” shall include an alien insurer except where clearly noted otherwise.

“Ultimate controlling person” means that person who is not controlled by any other person.

[ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—45.3(521A) Subsidiaries of domestic insurers. The authority to invest in subsidiaries under Iowa Code section 521A.2(3) is in addition to any authority to invest in subsidiaries which may be contained in any other provision of the insurance code.

An investment by a subsidiary under Iowa Code section 521A.2(3)“c” may cause the total investment of the insurer to exceed any of the limitations contained in any of the individual Iowa Code provisions referred to in section 521A.2(3)“c” provided that it does not exceed the aggregate amount which could be invested under all of those provisions with respect to the type of asset involved.

191—45.4(521A) Control acquisition of domestic insurer. Any person required to file a statement pursuant to Iowa Code section 521A.3 entitled “Acquisition of control of or merger with domestic insurer,” shall furnish all the information requested on Form A hereto annexed and hereby made a part of these rules.

45.4(1) If the person being acquired is a “domestic insurer” solely because of the provisions of Iowa Code section 521A.3(1), the name of the domestic insurer on the cover page should be as follows: “ABC Insurance Company, a Subsidiary of XYZ Holding Company.”

45.4(2) Where a domestic insurer, including any other person controlling a domestic insurer, unless such other person is either directly or through its affiliate primarily engaged in business other than the business of insurance is being acquired, references to “the insurer” contained in Form A shall refer to both the domestic subsidiary insurer and the person being acquired.

45.4(3) The applicant shall promptly advise the commissioner of any changes in the information so furnished arising subsequent to the date upon which such information was furnished but prior to the commissioner’s disposition of the application.

45.4(4) Exemptions. No statement need be filed and no approval by the commissioner is required pursuant to Iowa Code section 521A.3 if the company being acquired is considered a domestic insurer solely by reason of Iowa Code section 521A.3(1) and provided such acquisition is subject to disclosure requirements in said company’s state of domicile substantially similar to those imposed by Iowa Code section 521A.3.

191—45.5(521A) Registration of insurers.

45.5(1) Annual registration. Any insured required to file an annual registration statement pursuant to Iowa Code section 521A.4 shall furnish all the information required on Form B hereto annexed and hereby made a part of these rules.

45.5(2) Amendment to Form B. An amendment to Form B shall be filed within 15 days after the end of any month in which there is a material change to the information provided in the annual registration statement. Amendments shall be filed in the Form B format with only those items which are being amended reported. Each amendment shall include at the top of the cover page “Amendment No. [insert number] to Form B for [insert year]” and shall indicate the date of the change and not the date of the original filing.

45.5(3) Summary registration. An insurer required to file an annual registration statement pursuant to Iowa Code section 521A.4 is also required to furnish information required on Form C, hereby made a part of these rules. Form C shall include all amendments for the statement period.

[ARC 1844C, IAB 2/4/15, effective 1/14/15]

191—45.6(521A) Alternative and consolidated registrations. Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers which are required to register under section 521A.4. A registration statement may include information regarding any insurer in the insurance holding company system even if such insurer is not authorized to do business in this state. In lieu of filing a registration statement on Form B, the authorized insurer may file a copy of the registration statement or similar report which it is required to file in its state of domicile, provided:

1. The statement or report contains substantially similar information required to be furnished on Form B; and

2. The filing insurer is the principal insurance company in the insurance holding company system.

45.6(1) The question of whether the filing insurer is the principal insurance company in the insurance holding company system is a question of fact and an insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer shall set forth a simple statement of facts which will substantiate the filing insurer’s claim that it, in fact, is the principal insurer in the insurance holding company system.

45.6(2) With the prior approval of the commissioner, an unauthorized insurer may follow any of the procedures which could be done by an authorized insurer under subrule 45.6(1).

Any insurer may take advantage of the provisions of Iowa Code section 521A.4(7) or 521A.4(8) without obtaining the prior approval of the commissioner. The commissioner, however, reserves the right to require individual filings if the commissioner deems such filings necessary in the interest of clarity, ease of administration or the public good.

191—45.7(521A) Exemptions. A foreign or alien insurer otherwise subject to Iowa Code section 521A.4, shall not be required to register pursuant to that section if it is admitted in the domiciliary state of the principal insurer (as that term is defined in 45.6(1)) and in said state if subject to disclosure requirements and standards adopted by the statute or rules which are substantially the same as those contained in Iowa Code section 521A.4, provided, the commissioner may require a copy of the registration statement or other information filed with the domiciliary state.

45.7(1) The state of entry of an alien insurer shall be deemed to be its domiciliary state for the purposes of these rules.

45.7(2) Any insurer not otherwise exempt or excepted from Iowa Code section 521A.4 may apply for an exemption from the requirements of said section by submitting a statement to the commissioner setting forth its reasons for being exempt.

191—45.8(521A) Disclaimers and termination of registration. A disclaimer of affiliation or a request for termination of registration claiming that a person does not, or will not upon the taking of some proposed action, control another person (hereinafter referred to as the “subject”) shall contain the following information:

45.8(1) The number of authorized, issued and outstanding voting securities of the subject;

45.8(2) With respect to the person whose control is denied and all affiliates of such person, the number and percentage of shares of the subject's voting securities which are held of record or known to be beneficially owned, and the number of such shares concerning which there is a right to acquire, directly or indirectly;

45.8(3) All material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person;

45.8(4) A statement explaining why such person should not be considered to control the subject.

A request for termination of registration shall be deemed to have been granted unless the commissioner, within 30 days after receipt of the request, notifies the registrant otherwise.

191—45.9(521A) Transactions subject to prior notice—notice filing.

45.9(1) An insurer required to give notice of a proposed transaction pursuant to Iowa Code section 521A.5 shall furnish the required information on Form D, hereby made a part of these rules.

45.9(2) Agreements for cost-sharing services and management services shall, at a minimum and as applicable:

- a.* Identify the person providing services and the nature of such services;
- b.* Set forth the methods to allocate costs;
- c.* Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the Accounting Practices and Procedures Manual;
- d.* Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement;
- e.* State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance;
- f.* Define books and records of the insurer to include all books and records developed or maintained under or related to the agreement;
- g.* Specify that all books and records of the insurer are and shall remain the property of the insurer and are subject to control of the insurer;
- h.* State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer, and subject to the control of the insurer;
- i.* Include standards for termination of the agreement with and without cause;
- j.* Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services;
- k.* Specify that if the insurer is placed in receivership or seized by the commissioner under the state receivership Act:
 - (1) All of the rights of the insurer under the agreement extend to the receiver or the commissioner; and
 - (2) All books and records will immediately be made available to the receiver or the commissioner and shall be turned over to the receiver or the commissioner immediately upon the receiver's or the commissioner's request;
- l.* Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed in receivership pursuant to Iowa Code chapter 507C; and
- m.* Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure notwithstanding a seizure by the commissioner under Iowa Code chapter 507C, and will make them available to the receiver for so long as the affiliate continues to receive timely payment for services rendered.

[ARC 1844C, IAB 2/4/15, effective 1/14/15]

191—45.10(521A) Extraordinary dividends and other distributions.

45.10(1) Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders shall include the following:

- a.* The date established for payment of the dividend;
- b.* The amount of the proposed dividend;

c. A statement as to whether the dividend is to be in cash or other property and, if in property, a description thereof of its cost, and its fair market value together with an explanation of the basis for valuation;

d. A copy of the calculations used to determine that the proposed dividend is extraordinary, including the amounts and dates of all dividends (including regular dividends) paid within the period of 24 consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the second and immediately preceding years;

e. A balance sheet and statement of income for the period intervening from the last annual statement filed with the commissioner and the end of the month preceding the month in which the request for dividend approval is submitted;

f. A brief statement as to the effect of the proposed dividend upon the insurer’s surplus and the reasonableness of surplus in relation to the insurer’s outstanding liabilities and the adequacy of surplus relative to the insurer’s financial needs.

45.10(2) A dividend or distribution to an insurer’s shareholders which exceeds the greater of (a) 10 percent of the insurer’s surplus as regards policyholders as of the 31st day of December next preceding, or (b) the net gain from operations of such insurer if the insurer is a life insurer, or the net income if the insurer is not a life insurer, not including realized capital gains, for the 12-month period ending the 31st day of December next preceding shall be submitted to the commissioner 30 days in advance for approval. The commissioner may deem such dividend to be excessive and to constitute grounds under 191—subrule 110.4(5) for finding the insurer to be in a financially hazardous condition and subject to the provisions of 191—subrule 110.5(2).

[ARC 1844C, IAB 2/4/15, effective 1/14/15]

191—45.11(521A) Enterprise risk report. The ultimate controlling person of an insurer required to file an enterprise risk report pursuant to Iowa Code section 521A.4(12) shall furnish the required information on Form F, hereby made a part of these rules.

[ARC 1844C, IAB 2/4/15, effective 1/14/15]

191—45.12(521A) Forms—additional information and exhibits. In addition to the information expressly required to be included in Form A, Form B, Form C, Form D, and Form F, the commissioner may request such further material information, if any, as may be necessary to make the information contained therein not misleading. The person filing may also file such exhibits as the person may desire in addition to those expressly required by the statement. The exhibits shall be marked as to indicate clearly the subject matter to which they refer. Changes to Form A, B, C, D, or F shall include on the top of the cover page the phrase: “Change No. [insert number] to” and shall indicate the date of the change and not the date of the original filing.

[ARC 1844C, IAB 2/4/15, effective 1/14/15]

FORM A

STATEMENT REGARDING THE
ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER

Name of Domestic Insurer
BY

Name of Acquiring Person (Applicant)

Filed with the Insurance Division of Iowa

Dated: _____, 20 _____

Name, Title, Address and Telephone Number of Individual to Whom Notices and Correspondence Concerning This Statement Should be Addressed:

FORM A

Item 1. Insurer and method of acquisition.

State the name and address of the domestic insurer to which this application relates and a brief description of how control is to be acquired.

Item 2. Identity and background of the applicant.

(a) State the name and address of the applicant seeking to acquire control over the insurer.

(b) If the applicant is not an individual, state the nature of its business operations for the past five years or for such lesser period as such person and any predecessors thereof shall have been in existence. Briefly describe the business intended to be done by the applicant and the applicant's subsidiaries.

(c) Furnish a chart or listing clearly presenting the identities of the interrelationships among the applicant and all affiliates of the applicant. Indicate in such chart or listing the percentage of voting securities of each such person which is owned or controlled by the applicant or by any other such person. If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control. For each person specified in such chart or listing, indicate the type of organization (e.g., corporation, trust, partnership) and the state or other jurisdiction of domicile. If court proceedings involving a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, nature of proceedings and the date when commenced.

Item 3. Identity and background of individuals associated with the applicant.

On the biographical affidavit, include a third-party background check, and state the following with respect to (1) the applicant if an individual or (2) all persons who are directors, executive officers or owners of 10 percent or more of the voting securities of the applicant if the applicant is not an individual.

(a) Name and business address;

(b) Present principal business activity occupation or employment including position and office held and the name, principal business and address of any corporation or other organization in which such employment is carried on;

(c) Material occupations, positions, offices or employments during the last five years, giving the starting and ending dates of each and the name, principal business and address of any business corporation or other organization in which each such occupation, position, office or employment was carried on; if any such occupation, position, office or employment required licensing by or registration with any federal, state or municipal governmental agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension or disciplinary proceedings in connection therewith;

(d) Whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last ten years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case.

Item 4. Nature, source and amount of consideration.

(a) Describe the nature, source and amount of funds or other considerations used or to be used in effecting the merger or other acquisition of control. If any part of the same is represented or is to be represented by funds or other consideration borrowed or otherwise obtained for the purpose of acquiring, holding, or trading securities, furnish a description of the transaction, the names of the parties thereto, the relationship, if any, between the borrower and the lender, the amounts borrowed or to be borrowed, and copies of all agreements, promissory notes and security arrangements relating thereto.

(b) Explain the criteria used in determining the nature and amount of such consideration.

(c) If the source of the consideration is a loan made in the lender's ordinary course of business and if the applicant wishes the identity to remain confidential, the applicant must specifically request that the identity be kept confidential.

Item 5. Future plans for insurer.

Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate such insurer, to sell its assets to or merge it with any person or persons or to make any other material change in its business operations or corporate structure or management.

Item 6. Voting securities to be acquired.

State number of shares of the insurer's voting securities which the applicant, its affiliates and any person listed in Item 3 plan to acquire, and the terms of the offer, request, invitation, agreement or acquisition, and a statement as to the method by which the fairness of the proposal was arrived at.

Item 7. Ownership of voting securities.

State the amount of each class of any voting security of the insurer which is beneficially owned or concerning which there is a right to acquire beneficial ownership by the applicant, its affiliates or any person listed in Item 3.

Item 8. Contracts, arrangements or understandings with respect to voting securities of the insurer.

Give a full description of any contracts, arrangements or understandings with respect to any voting security of the insurer in which the applicant, its affiliates or any persons listed in Item 3 is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements or understandings have been entered into.

Item 9. Recent purchases of voting securities.

Describe any purchases of any voting securities of the insurer by the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement. Include in such description the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid therefor. State whether any such shares so purchased are hypothecated.

Item 10. Recent recommendations to purchase.

Describe any recommendations to purchase any voting security of the insurer made by the applicant, its affiliates or any person listed in Item 3, or by anyone based upon interviews or at the suggestion of the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement.

Item 11. Agreements with broker-dealers.

Describe the terms of any agreement, contract or understanding made with any broker-dealer as to solicitation of voting securities of the insurer for tender, and the amount of any fees, commissions or other compensation to be paid to broker-dealer, with regard thereto.

Item 12. Financial statements, exhibits, and three-year financial projections.

(a) Financial statements, exhibits, and three-year financial projections of the insurer(s) shall be attached to this statement as an appendix, but list under this item the financial statements, exhibits, and projections so attached.

(b) The financial statements shall include the annual financial statements of the persons identified in Item 2(c) for the preceding five fiscal years (or for such lesser period as such applicant and its affiliates and any predecessors thereof shall have been in existence), and similar information covering the period from the end of such person's last fiscal year, if such information is available. Such statements may be prepared on either an individual basis, or, unless the commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

The annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the applicant is an insurer which is actively engaged in the

business of insurance, the financial statements need not be certified, provided they are based on the Annual Statement of such person filed with the insurance department of the person's domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.

(c) File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and (if distributed) of additional soliciting material relating thereto; any proposed employment, consultation, advisory or management contracts concerning the insurer; annual reports to the stockholders of the insurer and the applicant for the last two fiscal years; and any additional documents or papers required by Form A.

Item 13. Agreement requirements for enterprise risk management. Applicant agrees to provide, to the best of its knowledge and belief, the information required by Form F within 15 days after the end of the month in which the acquisition of control occurs.

Item 14. Signature and certification. Signature and certification of the following form:

SIGNATURE

Pursuant to the requirements of Iowa Code section 521A.3,

_____ has caused this application to be duly signed on its
(Name of Applicant)
behalf in the City of _____ and State of _____, on the _____ day
of _____, 20 _____.

(SEAL)

(Name of Applicant)
By _____
(Name) (Title)

Attest:

(Signature of Officer)

(Title)

CERTIFICATION

The undersigned deposes and says that deponent has duly executed the attached application dated _____, 20 _____, for and on behalf of _____;

(Name of Applicant)

that deponent is the _____ of such company, and that deponent is authorized to
(Title of Officer)

execute and file such instrument. Deponent further says that deponent is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of the deponent's knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

FORM B

INSURANCE HOLDING COMPANY SYSTEM
ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Division of Iowa

By

Name of Registrant

On Behalf of the Following Insurance Companies

Name	Address

Date: _____, 20 _____

Name, Title, Address and Telephone Number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

FORM B

Item 1. Identity and control of registrant.

Furnish the exact name of each insurer registering or being registered (hereinafter called “the Registrant”), the home office address and principal executive offices of each; the date on which each Registrant became part of the insurance holding company system; and the method(s) by which control of each Registrant was acquired and is maintained.

Item 2. Organizational chart.

Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of such control. For each person specified in such chart or listing, indicate the type of organization (e.g., corporation, trust, partnership) and the state or other jurisdiction of domicile.

Item 3. The ultimate controlling person.

As to the ultimate controlling person in the insurance holding company system furnish all of the following information:

- (a) Name.
- (b) Home office address.
- (c) Principal executive office address.
- (d) The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.

(e) The principal business of the person.

(f) The name and address of any person who holds or owns 10 percent or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned.

(g) If court proceedings looking toward a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.

Item 4. Biographical information.

If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, furnish the following information for the directors and executive officers of the ultimate controlling person: The individual's name, address, principal occupation and all offices and positions held during the past five years; and any conviction of crimes other than minor traffic violations. If the ultimate controlling person is an individual, furnish the individual's name and address, the individual's principal occupation and all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations.

Item 5. Transactions, relationships and agreements.

(a) Briefly describe the following agreements in force, relationships subsisting, and transactions currently outstanding or which have occurred during the last calendar year between the Registrant and its affiliates:

(1) Loans, other investments or purchases, sales or exchanges of securities of the affiliates by the Registrant or of the Registrant by its affiliates;

(2) Purchases, sales or exchanges of assets;

(3) Transactions not in the ordinary course of business;

(4) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the Registrant's business;

(5) All management and service contracts and all cost-sharing arrangements, other than cost allocation arrangements based upon generally accepted accounting principles;

(6) Reinsurance agreements;

(7) Dividends and other distributions to shareholders; and

(8) A pledge of the insurer's stock, including stock of a subsidiary or controlling affiliate, for a loan made to a member of the insurance holding company system.

No information need be disclosed if such information is not material. Sales, purchases, exchanges, loans or extensions of credit or investments involving one-half of 1 percent or less of the Registrant's admitted assets as of the 31st day of December next preceding shall not be deemed material.

The description shall be in a manner as to permit the proper evaluation thereof by the commissioner, and shall include at least the following: the nature and purpose of the transaction; the nature and amounts of any payments or transfers of assets between the parties; the identity of all parties to such transaction; and relationship of the affiliated parties to the Registrant.

Item 6. Litigation or administrative proceedings.

A brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which litigation or proceeding is or was pending:

(a) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and

(b) Proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations.

Item 7. Financial statements and exhibits.

(a) Financial statements and exhibits should be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, the financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year.

If at the time of the initial registration the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis or, unless the commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

Other than with respect to the foregoing, such financial statement shall be filed in a standard form and format adopted by the National Association of Insurance Commissioners, unless an alternative form is accepted by the commissioner. Documentation and financial statements filed with the Securities and Exchange Commission or audited generally accepted accounting principles financial statements shall be deemed to be an appropriate form and format.

Unless the commissioner otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer who is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the Annual Statement of such insurer's domiciliary state and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.

Any ultimate controlling person who is an individual may file personal financial statements that are reviewed rather than audited by an independent public accountant. The review shall be conducted in accordance with standards for review of personal financial statements published in the Personal Financial Statements Guide by the American Institute of Certified Public Accountants. In order for personal financial statements to be in conformity with generally accepted accounting principles, the statements shall be accompanied by the independent public accountant's standard review report stating that the accountant is not aware of any material modifications that should be made to the financial statements.

(c) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or papers required by Form B requested by the commissioner, Form A, or documents otherwise required by the commissioner to be filed.

Item 8. Annual Form C required. A Form C, Summary of Changes to Registration Statement, shall be prepared and filed with this Form B.

SIGNATURES

Signatures and certification of the form as follows:

SIGNATURE

Pursuant to the requirements of Iowa Code section 521A.4 and rule 191—45.5(521A), the Registrant has caused this registration statement to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 20 _____.

(SEAL)

(Name of Registrant)

By _____
(Name) (Title)

Attest:

(Signature of Officer)

(Title)

CERTIFICATION

The undersigned deposes and says that deponent has duly executed the attached annual registration statement dated _____, 20 _____, for and on behalf of _____;

(Name of Company)

that deponent is the _____ of such company, and that deponent is authorized to
(Title of Officer)

execute and file such instrument. Deponent further says that deponent is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of the deponent's knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

[ARC 1844C, IAB 2/4/15, effective 1/14/15]

FORM C
SUMMARY OF CHANGES TO REGISTRATION STATEMENT

Filed with the Insurance Division of Iowa

By _____
Name of Registrant

On Behalf of the following insurance companies

Name	Address
_____	_____
_____	_____
_____	_____

Date: _____, 20 _____

Name, title, address and telephone number of individual to whom notices and correspondence concerning this summary should be addressed:

Furnish a brief description of all items in the current annual registration statement which represented changes from the prior year's annual registration statement. The description shall be in a manner as to permit the proper evaluation thereof by the commissioner, and shall include specific references to item numbers in the annual registration statement and to the terms contained therein.

Changes occurring under Item 2 of Form B, insofar as changes in the percentage of each class of voting securities held by each affiliate are concerned, need be included only where such changes are ones which result in ownership or holdings of 10 percent or more of voting securities, loss or transfer of control, or acquisition of loss of partnership interest.

Changes occurring under Item 4 of Form B need be included only where: an individual is, for the first time, made a director or executive officer of the ultimate controlling person; a director or executive officer terminates their responsibilities with the ultimate controlling person; or in the event an individual is named president of the ultimate controlling person.

If a transaction disclosed on the prior year's annual registration statement has been changed, the nature of such change shall be included. If a transaction disclosed on the prior year's annual registration statement has been effectuated, furnish the mode of completion and describe any flow of funds between affiliates resulting from the transaction.

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions whose purpose it is to avoid statutory threshold amounts and the review that might otherwise occur.

SIGNATURE

Pursuant to the requirements of Iowa Code section 521A.4, the registrant has caused this summary of registration statement to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 20 _____.

 (Name of Registrant)

 (Name) (Title)

Attest:

 (Signature of Officer)

 (Title)

(SEAL)

CERTIFICATION

The undersigned deposes and says that having duly executed the attached summary of registration statement dated _____, 20 _____, for and on behalf of _____; as _____ of such company, with

(Name of Company)

(Title of Officer)

authority to execute and file such instrument, deponent is familiar with such instrument and the facts therein set forth are true to the best of deponent's knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

[ARC 1844C, IAB 2/4/15, effective 1/14/15]

FORM D
PRIOR NOTICE OF A TRANSACTION

Filed with the Insurance Division of Iowa

By

Name of insurer filing notice

On behalf of the following insurance companies

Name	Address
_____	_____
_____	_____
_____	_____

Date: _____, 20 _____

Name, title, address and telephone number of individual to whom notices and correspondence concerning this summary should be addressed:

Item 1. Identity of parties to transaction.

Furnish the following information for each of the parties to the transaction:

- (a) Name.
- (b) Home office address.
- (c) Principal executive office address.
- (d) The organizational structure, i.e., corporation, partnership, individual, trust, etc.
- (e) A description of the nature of the parties' business operations.
- (f) Relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties.
- (g) Where the transaction is with a nonaffiliate, the name(s) of the affiliate(s) which will receive, in whole or in substantial part, the proceeds of the transaction.

Item 2. Description of the transaction.

Furnish the following information for each transaction for which notice is being given:

- (a) A statement as to whether notice is being given under Iowa Code section 521A.5(1) "b" or section 521A.5(1) "c."
- (b) A statement of the nature of the transaction.
- (c) A statement describing how the transaction meets the "fair and reasonable" standard under Iowa Code section 521A.5(1) "a"(1).
- (d) The proposed effective date of the transaction.

Item 3. Sales, purchases, exchanges, loans, extensions of credit, guarantees, or investments.

Furnish a brief description of the amount and source of funds, securities, property or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee, or investment,

whether any provision exists for purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice; a description of the terms of any securities being received, if any; and a description of any other agreements relating to the transaction such as contracts, agreements for services, or consulting agreements. If the transaction involves other than cash, furnish a description of the consideration, its cost and its fair market value, together with an explanation of the basis for evaluation.

If the transaction involves a loan, extension of credit or a guarantee, furnish a description of the maximum amount which the insurer will be obligated to make available under such loan, extension of credit or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest.

If the transaction involves an investment, guarantee or other arrangement, state the time period during which the investment, guarantee or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees or arrangements. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

If the transaction involves a loan or extension of credit to any person who is not an affiliate, furnish a brief description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit, and specify in what manner the proceeds are to be used to loan to, extend credit to, purchase assets of or make investments in any affiliate. Describe the amount and source of funds, securities, property or other consideration for the loan or extension of credit and, if the transaction is one involving consideration other than cash, a description of its cost and its fair market value together with an explanation of the basis for evaluation. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the sale, purchase, exchange, loan, extension of credit, guarantee or investment is one which is less than the greater of 5 percent of the insurer's admitted assets or 25 percent of surplus as regards policyholders.

Item 4. Reinsurance.

If the transaction is a reinsurance agreement or modification thereto, or a reinsurance pooling agreement or modification thereto, as described in Iowa Code section 521A.5(1) "c," furnish a description of the known or estimated amount of liability to be ceded or assumed in each calendar year, the period of time during which the agreement will be in effect, and a statement of whether an agreement will be in effect, and a statement of whether an agreement or understanding exists between the insurer and a nonaffiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one or more of the insurer's affiliates. Furnish a brief description of the consideration involved in the transaction and a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given for reinsurance agreements or modification thereto if the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or change in the insurer's liabilities in any of the next three years, in connection with the reinsurance agreement or modification thereto is less than 5 percent of the insurer's surplus as regards policyholders, as of the preceding 31st day of December. Notice shall be given for all reinsurance pooling agreements including modifications thereto.

Item 5. Management agreements, service agreements and cost-sharing agreements.

For management and service agreements, furnish:

- (a) A brief description of the managerial responsibilities or services to be performed; and
- (b) A brief description of the agreement, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made.

For cost-sharing arrangements, furnish:

- (a) A brief description of the purpose of the agreement;
- (b) A description of the period of time during which the agreement is to be in effect;
- (c) A brief description of each party's expenses or costs covered by the agreement;

(d) A brief description of the accounting basis to be used in calculating each party's costs under the agreement;

(e) A brief statement as to the effect of the transaction upon the insurer's policyholder surplus;

(f) A statement regarding the cost allocation methods that specifies whether the proposed charges are based on cost or market. If the proposed charges are market-based, the rationale for using market instead of cost, including justification for the company's determination that amounts are fair and reasonable, shall be included; and

(g) A statement regarding compliance with the NAIC Accounting Practices and Procedures Manual regarding expense allocation.

Pursuant to the requirements of Iowa Code section 521A.5, the applicant has caused this notice to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 20 _____.

By: _____
(Name) (Title)

Attest:

(Signature of Officer)

(Title)

(SEAL)

CERTIFICATION

The undersigned acknowledges that having duly executed the attached prior notice of a transaction dated _____, 20 _____, for and on behalf of _____;

(Name of Company)

as _____ of such company, with authority to execute and file such instrument,
(Title of Officer)

deponent is familiar with such instrument and the facts therein set forth are true to the best of deponent's knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

[ARC 1844C, IAB 2/4/15, effective 1/14/15]

FORM F
ENTERPRISE RISK REPORT

Filed with the Insurance Division of the State of Iowa

By

Name of Registrant/Applicant

On Behalf of/Related to the Following Insurance Companies

Name	Address
_____	_____
_____	_____
_____	_____

Date: _____, 20 _____

Name, Title, Address and Telephone Number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

Item 1. Enterprise risk.

The registrant/applicant, to the best of its knowledge and belief, shall provide information regarding the following areas that could produce enterprise risk as defined in Iowa Code section 521A.1(5) provided such information is not disclosed in the insurance holding company system annual registration statement filed on behalf of the registrant/applicant or another insurer for which the registrant/applicant is the ultimate controlling person:

- (a) Any material developments regarding strategy, internal audit findings, compliance or risk management affecting the insurance holding company system;
- (b) Acquisition or disposal of insurance entities and reallocating of existing financial or insurance entities within the insurance holding company system;
- (c) Any changes of shareholders of the insurance holding company system exceeding 10 percent or more of voting securities;
- (d) Developments in various investigations, regulatory activities or litigation that may have a significant bearing or impact on the insurance holding company system;
- (e) Business plan of the insurance holding company system and summarized strategies for the next 12 months;
- (f) Identification of material concerns of the insurance holding company system raised by supervisory college, if any, in the last year;
- (g) Identification of insurance holding company system capital resources and material distribution patterns;
- (h) Identification of any negative movement or discussions with rating agencies which may have caused, or may cause, potential negative movement in the credit ratings and individual insurer financial strength ratings assessment of the insurance holding company system (including both the rating score and outlook);
- (i) Information on corporate or parental guarantees throughout the holding company and the expected source of liquidity should such guarantees be called upon; and
- (j) Identification of any material activity or development of the insurance holding company system that, in the opinion of senior management, could adversely affect the insurance holding company system.

The registrant/applicant may attach the appropriate form most recently filed with the U.S. Securities and Exchange Commission, provided the registrant/applicant includes specific references to those areas listed in Item 1 for which the form provides responsive information. If the registrant/applicant is not domiciled in the United States, it may attach its most recent public audited financial statement filed in its country of domicile, provided the registrant/applicant includes specific references to those areas listed in Item 1 for which the financial statement provides responsive information.

Item 2. Obligation to report.

If the registrant/applicant has not disclosed any information pursuant to Item 1, the registrant/applicant shall include a statement affirming that, to the best of its knowledge and belief, it has not identified enterprise risk subject to disclosure pursuant to Item 1.

[ARC 1844C, IAB 2/4/15, effective 1/14/15]

These rules are intended to implement Iowa Code sections 521A.4 and 521A.8.

[Filed 11/19/70; amended 12/14/72]

[Filed 2/23/83, Notice 1/19/83—published 3/16/83, effective 4/20/83]

[Filed 8/21/86, Notice 7/16/86—published 9/10/86, effective 10/15/86]

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

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

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

[Filed Emergency After Notice ARC 1844C (Notice ARC 1784C, IAB 12/10/14), IAB 2/4/15,
effective 1/14/15]

[Filed ARC 5515C (Notice ARC 5389C, IAB 1/13/21), IAB 3/10/21, effective 4/14/21]

CHAPTER 46
MUTUAL HOLDING COMPANIES

191—46.1(521A) Purpose. This chapter is intended to implement the provisions of Iowa Code section 521A.14 to provide for:

46.1(1) The formation of a mutual insurance holding company through an application process subject to regulation by the division. A domestic mutual insurance company may reorganize by forming a mutual insurance holding company based upon a mutual plan. The reorganized insurance company shall continue, without interruption, its corporate existence as a stock insurance company subsidiary to the mutual insurance holding company or as a stock insurance company subsidiary to an intermediate holding company which is subsidiary to the mutual insurance holding company.

46.1(2) The reorganization of a domestic mutual insurance company by merging its policyholders' membership interests into a mutual insurance holding company and continuing, without interruption, the corporate existence of the reorganized insurance company as a stock insurance company subsidiary to the mutual insurance holding company or as a stock insurance company subsidiary to an intermediate holding company which is a subsidiary to the mutual insurance holding company through an application process subject to regulation by the division.

46.1(3) An application process for the approval of an initial sale of the shares of the capital stock of a reorganized domestic insurance company or an intermediate holding company, subject to the approval of the division.

[ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—46.2(521A) Definitions. In addition to the definitions in 191—1.1(502,505), the following definitions apply to this chapter:

"Affiliated person" of another person means:

1. Any person directly or indirectly owning, controlling, or holding with power to vote, 5 percent or more of the outstanding voting securities of such other person,
2. Any person 5 percent or more of whose outstanding voting securities are directly or indirectly owned, controlled, or held with power to vote, by such other person,
3. Any person directly or indirectly controlling, controlled by, or under common control with, such other person, or
4. Any officer, director, partner, copartner, or employee of such other person.

"Domestic mutual insurance company" means an insurance company organized on a mutual plan and incorporated under the laws of Iowa.

"Interested person" of another person means:

1. Any affiliated person of such company,
2. Any member of the immediate family of any natural person who is an affiliated person of such company,
3. Any person or partner or employee of any person who at any time since the beginning of the last two completed fiscal years of such company has acted as legal counsel for such company, or
4. Any natural person whom the commissioner by order shall have determined to be an interested person by reason of having had, at any time since the beginning of the last two completed fiscal years of such company, a material business or professional relationship with such company or with the principal executive officer of such company.

"Intermediate holding company" means a holding company which is a subsidiary of a mutual insurance holding company or part of a holding company system controlled by a mutual insurance holding company pursuant to the provisions of Iowa Code chapter 521A.

"Limited application" means an application by a domestic mutual insurance company for reorganization to a mutual insurance holding company which will hold, at all times, 100 percent of the stock of its insurance subsidiaries.

"Member of the immediate family" means any parent, spouse of a parent, child, spouse of a child, spouse, brother or sister, and includes step and adoptive relationships.

“*Mutual insurance holding company*” means a holding company organized on a mutual plan and incorporated under the laws of Iowa, resulting from the reorganization of a domestic mutual insurance company pursuant to the provisions of Iowa Code section 521A.14, with one or more stock insurance holding company subsidiaries or stock insurance company subsidiaries. A mutual insurance holding company shall be a person as defined in Iowa Code section 521A.1 and shall be subject to the provisions of Iowa Code chapter 521A.

“*Plan of reorganization*” means a plan to reorganize a domestic mutual insurance company by forming a mutual insurance holding company.

“*Standard application*” means an application by a domestic mutual insurance company for reorganization to a mutual insurance holding company which may sell interests in its subsidiaries to third parties.

“*Stock*” means any security evidencing an equity interest in the issuing entity.

“*Stock offering*” means any proposed sale, exchange, transfer or other change of ownership of stock or of securities convertible into or exchangeable or exercisable for stock. For the purposes of these rules, “stock offering” shall not mean (1) an offering of preferred stock which is not convertible or exchangeable into common stock and which has no ordinary voting rights or (2) a transfer of stock between any of the following:

- A mutual insurance holding company,
- An insurance company subsidiary of a mutual insurance holding company,
- An intermediate holding company subsidiary of a mutual insurance holding company, and
- An insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company.

[ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—46.3(521A) Application—contents—process.

46.3(1) An application shall be designated as either:

- a. A limited application, or
- b. A standard application.

The filing of a limited application shall not preclude the subsequent filing of an application for approval of an initial sale of stock as provided in rule 46.9(521A).

46.3(2) The application shall be filed in triplicate with the commissioner and shall include the following information:

- a. Designation as a limited or standard application.
- b. A plan of reorganization as set forth in 191—46.4(521A).
- c. A plan to obtain the approval of the policyholders in accordance with the applicant’s articles of incorporation and bylaws. Policyholders shall be given not less than 20 days’ notice of any vote on approval of reorganization.
- d. A copy of the mutual insurance holding company’s proposed articles of incorporation and bylaws specifying all membership rights.
- e. The names, addresses and occupational information of all corporate officers and members of the initial mutual insurance holding company board of directors.
- f. Information sufficient to demonstrate that the financial condition of the applicant will not be diminished upon reorganization.
- g. A copy of the proposed articles of incorporation and bylaws for any insurance company subsidiary or intermediate holding company subsidiary.
- h. A “Form A” filing as described in 191—Chapter 45, Iowa Administrative Code.
- i. An index demonstrating where in the application information supplied in compliance with each of these rules is found.
- j. Any other information requested by the commissioner at any time during the course of proceedings.

46.3(3) Upon receipt and review by the commissioner of all information provided pursuant to 46.3(2), a hearing shall be held as provided in Iowa Code section 521A.3, subsection 4, paragraph “b.” The applicant shall present evidence establishing:

- a. The application is in compliance with all pertinent Iowa Code sections and administrative rules; and
- b. The requirements for a plan of reorganization have been fulfilled.

Notice of the hearing shall be given at least 20 days prior to the hearing by the insurance division by regular mail to all interested parties known to the division.
[ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—46.4(521A) Plan of reorganization.

46.4(1) A limited application plan of reorganization shall include provisions:

- a. Establishing a mutual insurance holding company with at least one stock insurance company subsidiary or one intermediary stock holding company with a stock insurance company subsidiary, the shares of which shall be held exclusively by the mutual insurance holding company.
- b. Protecting the interests of existing policyholders.
- c. Ensuring immediate membership in the mutual insurance holding company of all existing policyholders of the reorganizing domestic mutual insurance company.
- d. Describing a plan providing for membership interests of future policyholders.
- e. Describing the number of members of the board of directors of the mutual insurance holding company required to be policyholders.
- f. Demonstrating that, in the event of proceedings under Iowa Code chapter 507C involving a stock insurance company subsidiary of the mutual insurance holding company which resulted from the reorganization of a domestic mutual insurance company, the assets of the mutual insurance holding company will be available to satisfy the policyholder obligations of the stock insurance company.
- g. Describing a plan how any accumulation or prospective accumulation of earnings by the mutual insurance holding company which is or would be in excess of that determined by the board of directors of the mutual insurance holding company to be necessary shall inure to the exclusive benefit of the policyholders of its insurance company subsidiaries who are members.
- h. Describing the nature and content of the annual report and financial statement to be sent to each member.
- i. For other matters, as the applicant deems appropriate.

46.4(2) A standard application plan of reorganization shall include provisions:

- a. Establishing a mutual insurance holding company with at least one stock insurance company subsidiary or one wholly owned intermediate stock holding company with a stock insurance company subsidiary, the shares of which shall be held exclusively by the wholly owned intermediate holding company.
- b. Protecting the interests of existing policyholders.
- c. Ensuring immediate membership in the mutual insurance holding company of all existing policyholders of the reorganizing domestic mutual insurance company.
- d. Providing for membership interests of future policyholders.
- e. Describing the number of members of the board of directors of the mutual insurance holding company required to be policyholders.
- f. Demonstrating that, in the event of proceedings under Iowa Code chapter 507C involving a stock insurance company subsidiary of the mutual insurance holding company which resulted from the reorganization of a domestic mutual insurance company, the assets of the mutual insurance holding company will be available to satisfy the policyholder obligations of the stock insurance company.
- g. Describing how any accumulation or prospective accumulation of earnings by the mutual insurance holding company, which is or would be in excess of that determined by the board of directors of the mutual insurance holding company to be necessary, shall inure to the exclusive benefit of the policyholders of its insurance company subsidiaries who are members.

h. Describing the nature and content of the annual report and financial statement to be sent to each member.

i. Describing the applicant's plan for a stock offering in accordance with the provisions of rule 191—46.10(521A) below.

j. Describing other relevant matters the applicant deems appropriate.

46.4(3) With regard to either a limited or standard application, the plan of reorganization submitted to the commissioner shall demonstrate:

a. Policyholder interests are properly preserved and protected.

b. The plan is fair and equitable to policyholders.

c. The financial condition of the applicant will not be diminished.

[ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—46.5(521A) Duties of the commissioner.

46.5(1) The commissioner shall at all times retain jurisdiction over the mutual insurance holding company and its intermediate holding company subsidiaries with stock insurance company subsidiaries.

46.5(2) Following the hearing provided in 46.3(3) the commissioner shall, by order, approve, conditionally approve, or deny an application. The commissioner may require, as a condition of approval of the proposed reorganization, such modifications of the proposed plan of reorganization as the commissioner finds necessary. The applicant shall accept such required modifications by filing appropriate amendments to the proposed plan of reorganization with the commissioner within 30 days of the date of the order of the commissioner requiring such modifications. If the applicant does not accept such required modifications by failing to file the required amendments to the proposed plan of reorganization within 30 days, the proposed reorganization shall be deemed denied.

46.5(3) An approval or conditional approval of a plan of reorganization shall expire if the reorganization is not completed within 180 days unless such time period is extended by the commissioner upon a showing of good cause.

46.5(4) The commissioner may revoke approval or conditional approval of an applicant's plan of reorganization in the event the commissioner finds the applicant has failed to comply with the plan of reorganization. The commissioner may compel completion of a plan of reorganization pursuant to Iowa Code section 521A.9 unless the plan is abandoned in its entirety, in accordance with the applicant's provisions for governance. The commissioner shall retain jurisdiction over the applicant until a plan of reorganization has been completed.

46.5(5) Upon completion of all elements of a plan of reorganization, the applicant shall provide a notice of completion to the commissioner.

191—46.6(521A) Regulation—compliance.

46.6(1) Mutual insurance holding companies shall comply with the provisions of Iowa Code chapter 521A except as expressly provided herein.

46.6(2) No regulatory standards are waived during the pendency of an application for a plan of reorganization.

46.6(3) Mergers and acquisitions by a mutual insurance holding company must be approved by the commissioner pursuant to Iowa Code chapters 521 and 521A. At such time as a mutual insurance holding company acquires or plans to acquire more than 50 percent of a stock insurance company, the mutual insurance holding company shall submit to the commissioner a plan describing any membership interests of policyholders.

46.6(4) Each mutual insurance holding company shall supply to the insurance division, by April 1 of each year, an annual statement consisting of the following:

a. An income statement.

b. A balance sheet.

c. A cash flow statement.

d. Complete information on the status of any closed block formed as a part of a plan of reorganization.

- e.* An investment plan covering all assets.
- f.* A statement disclosing any intention to pledge, borrow against, alienate, hypothecate or in any way encumber the assets of the mutual insurance holding company.

46.6(5) At least 50 percent of the generally accepted accounting practices (GAAP) net worth of a mutual insurance holding company shall be invested in insurance company subsidiaries.

46.6(6) No policyholder who is a member of a mutual insurance holding company shall receive on account of such membership interest any payment of a policy credit, dividend or other distribution unless such payment has been approved by the commissioner. The commissioner, after a public hearing as provided in Iowa Code section 521A.3(4) “b,” if satisfied the proposed payment is fair and equitable to policyholders who are members, may approve the proposed payment and may require as a condition of such approval modification of the proposed payment as the commissioner finds necessary for the protection of such policyholders.

191—46.7(521A) Reorganization of domestic mutual insurer with mutual insurance holding company. A domestic mutual insurance company may apply to reorganize by merging its policyholders’ membership interests into a mutual insurance holding company by filing with the commissioner a joint application with the mutual insurance holding company complying with the provisions of 191—46.3(521A).

[ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—46.8(521A) Reorganization of foreign mutual insurer with mutual insurance holding company. A foreign mutual insurance company, or a foreign health service corporation, which if a domestic corporation would be organized under Iowa Code chapter 514, may apply to reorganize by merging its policyholders’ membership interests into a mutual insurance holding company by filing with the commissioner a joint application with the mutual insurance holding company complying with the provisions of 191—46.3(521A).

[ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—46.9(521A) Mergers of mutual insurance holding companies. A mutual insurance holding company may apply to merge with another mutual insurance holding company by filing with the commissioner a plan of merger and complying with the provisions of Iowa Code chapters 521 and 521A.

191—46.10(521A) Stock offerings.

46.10(1) No stock offering by a mutual insurance holding company, an insurance company subsidiary of a mutual insurance holding company, an intermediate holding company subsidiary of a mutual insurance holding company, or an insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company shall occur without the prior approval of the commissioner. The commissioner’s approval may be obtained only through the application and hearing process described below.

46.10(2) Every application for approval of a stock offering shall contain the following information:

- a.* A description of the stock intended to be offered by the applicant, including a description of all shareholder rights.
- b.* The total number of shares authorized to be issued, the estimated number the applicant requests permission to offer, and the intended date or range of dates for the offer.
- c.* A justification for a uniform planned offering price or a justification of the method by which the offering price will be determined.
- d.* The name or names of any underwriter, syndicate member or placement agent involved and, if known, the name or names of each entity, person, or group of persons to whom the stock offering is to be made who will control 5 percent of the total outstanding class of shares, and the manner in which the offer is to be tendered. If any such entity or person is a corporation or business organization, the name of each member of its board of directors or equivalent management team shall be provided along with the name of each member of the board of directors of the offeror. Copies of any filings with the

Securities and Exchange Commission disclosing intended acquisitions of the stock shall be included in the application.

e. A description of stock subscription rights to be afforded members of the mutual insurance holding company in conjunction with the stock offering.

f. A detailed description of all expenses to be incurred in conjunction with the stock offering.

g. An explanation of how funds raised by the stock offering are to be used.

h. Any other information requested by the commissioner.

46.10(3) No application regarding a planned stock offering shall be approved unless the plan contains provisions:

a. Prohibiting officers, directors, and insiders of the mutual insurance holding company and its subsidiaries and affiliates from purchase or ownership of shares of the stock offering, or issuance of stock options to or for the benefit of such officers, directors and insiders, for a period of at least six months following the first date the offering was publicly and regularly traded. This paragraph shall not be construed to limit the rights of officers, directors and insiders from exercising subscription rights generally accorded members of the mutual insurance holding company, except that, pursuant to such subscription rights, the officers, directors and insiders of the mutual insurance holding company and its subsidiaries and affiliates may not purchase or own, in the aggregate, more than 5 percent of the stock offering for a period of at least six months following the first date the offering was publicly and regularly traded.

b. Requiring a majority of the members of the board of directors of the mutual insurance holding company to be persons who are not interested persons of the mutual insurance holding company or of an affiliated person of such company. The commissioner may waive this requirement upon a showing of good cause.

c. For the mutual insurance holding company to adopt articles of incorporation prohibiting any waiver of dividends from stock subsidiaries except under conditions specified in its articles of incorporation and after approval of the waiver by the board of directors of the mutual insurance holding company and the commissioner.

d. Requiring that, after the initial stock offering by an insurance company subsidiary of a mutual insurance holding company, an intermediate holding company subsidiary of a mutual insurance holding company, or an insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company, the boards of directors of each such insurance company or intermediate holding company include at least three directors who are not interested persons of the mutual insurance holding company.

e. Establishing, within the board of directors of the corporation offering stock, a pricing committee consisting exclusively of directors who are not interested persons whose responsibility is to evaluate and approve the price of any stock offering.

46.10(4) An insurance company subsidiary of a mutual insurance holding company, an intermediate holding company subsidiary of a mutual insurance holding company, or an insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company may issue more than one class of stock provided, however, that at all times a majority of the voting stock is held by the mutual insurance holding company or its subsidiary and, provided further, that no class of common stock may possess greater dividend or other rights than the class held by the mutual insurance holding company or its subsidiary.

46.10(5) The commissioner may hire, at the applicant's expense, attorneys, actuaries, accountants, investment bankers and other experts as may reasonably be necessary to assist the commissioner in reviewing the application.

46.10(6) The commissioner may, in the commissioner's discretion, hold a public hearing regarding any application for approval of a stock offering. Upon receipt of an application for approval of a stock offering which includes an initial offering of stock, the commissioner shall hold a public hearing at which all interested parties may appear and present evidence and argument regarding the applicant's planned offering. The commissioner shall provide the applicant adequate notice of the hearing, such that applicant can provide notice of the hearing to members of the mutual insurance holding company, in a

manner approved by the commissioner, not less than 20 days prior to the hearing. Following the hearing, the commissioner may approve, conditionally approve, or deny the application. The commissioner may approve the plan if:

- a.* The offering complies with these rules and other provisions of law,
- b.* The method for establishing the price of a stock offering is consistent with generally accepted market or industry practices for establishing stock offering prices in similar transactions, and
- c.* The plan and offering will not unfairly impact the interests of members of the mutual insurance holding company.

None of the foregoing shall be deemed to prohibit the filing of a registration statement with the Securities and Exchange Commission prior to or concurrently with the giving of notice to members.

46.10(7) Notwithstanding the provisions of 46.10(1) to 46.10(6) above, stock offerings which are not an initial stock offering, and which offer stock regularly traded on the New York Stock Exchange, the American Stock Exchange, or another exchange approved by the commissioner, or designated on the national association of securities dealers automated quotations—national market system (NASDAQ), may be sold in accordance with the following procedure: If a mutual insurance holding company, an insurance company subsidiary of a mutual insurance holding company, an intermediate holding company, or an insurance company subsidiary of an intermediate holding company intends to make a stock offering which would be governed by the provisions of this subrule, that entity shall deliver to the commissioner, not less than 30 days prior to the offering, a notice of the planned stock offering and information regarding *(a)* the total number of shares intended to be offered, *(b)* the intended date of sale, *(c)* evidence the stock is regularly traded on one of the public exchanges noted above, and *(d)* a record of the trading price and trading volume of the stock during the prior 52 weeks. The commissioner shall be deemed to have approved the sale unless, within 30 days following receipt of such notice, the commissioner issues an objection to the sale. If the commissioner issues an objection to the sale, the procedures set forth in subrule 46.10(2) shall be followed to determine whether the commissioner approves of the proposed sale.

46.10(8) Approval of a stock offering obtained under either subrule 46.10(6) or 46.10(7) above shall expire 90 days following the date of the approval or deemed approval, except as otherwise provided by order of the commissioner.

46.10(9) No prospectus, information, sales material or sales presentation by the applicant, or by any representative, agent or affiliate of the applicant, shall contain a representation that the commissioner's approval of a stock offering constitutes an endorsement of the price, price range, or any other information relating to the stock.

46.10(10) The following practices are prohibited:

- a.* Borrowing funds from the mutual insurance holding company, or its subsidiaries and affiliates, to finance the purchase of any portion of a stock offering.
- b.* Payment of commissions, "special fees" and any other special payments or extraordinary compensation to officers, directors, interested persons and affiliates, for arranging, promoting, aiding or assisting in reorganization to a mutual insurance holding company, or for arranging, promoting, aiding, assisting or participating in the structuring and placement of a stock offering.
- c.* Entering into an understanding or agreement transferring legal or beneficial ownership of stock to another person in avoidance of these rules.

191—46.11(521A) Regulation of holding company system.

46.11(1) A mutual insurance holding company, and its subsidiaries and affiliates, shall be subject to all provisions of Iowa Code chapter 521A, "Insurance Holding Company Systems." In addition to the provisions of that chapter, all material transactions, as that term is defined in Iowa Code chapters 521A and 521D, between subsidiaries and affiliates of the mutual insurance holding company must be approved by a majority of the directors of the mutual insurance holding company as being both *(a)* fair and reasonable and *(b)* made on terms and conditions not less favorable than those available from unaffiliated third parties.

46.11(2) If the commissioner finds, after notice and hearing, that activities within a mutual insurance holding company system have violated provisions of the Iowa Code, have violated administrative rules, or act to circumvent requirements or prohibitions contained in the Iowa Code or administrative rules, the commissioner may prohibit or order rescission of any transaction relating to those activities.

191—46.12(521A) Reporting of stock ownership and transactions.

46.12(1) Any director or officer of a mutual insurance holding company, its subsidiary or affiliate, who acquires directly or indirectly the beneficial ownership of any security issued by any member of the mutual insurance holding company system shall, within 15 days following the transaction, file with the insurance commissioner a statement of the transaction on the form prescribed by the commissioner.

46.12(2) A mutual insurance holding company, and its subsidiaries and affiliates, shall file with the commissioner, within 15 days of receipt, copies of Form 3, Form 4 and Schedule 13D, or any equivalent filings, such filings made under the Securities Exchange Act of 1934, as amended.

These rules are intended to implement Iowa Code section 521A.14.

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VIATICAL AND LIFE SETTLEMENTS
CHAPTER 48
VIATICAL AND LIFE SETTLEMENTS

191—48.1(508E) Purpose and authority. The purpose of this chapter is to provide for the administration of viatical and life settlements in this state by providing rules under which viatical and life settlements may be made, disclosures and other provisions by which viators may be protected, and safeguards by which viatical settlement providers may be monitored and remain in good standing. These rules are adopted by the commissioner pursuant to the authority in Iowa Code chapter 508E. [ARC 7729B, IAB 4/22/09, effective 4/3/09]

191—48.2(508E) Definitions. For purposes of this chapter, the definitions in Iowa Code section 508E.2 are incorporated by reference. In addition to those definitions and the definitions in rule 191—1.1(502,505), the following definitions apply:

“*Life settlement*” means a viatical settlement in which the viator has not been diagnosed as terminally or chronically ill. For purposes of these rules, unless otherwise distinguished, the term “life settlement” shall be synonymous with viatical settlement.

“*Renewal year*” means the last year of the viatical settlement license three-year term. [ARC 7729B, IAB 4/22/09, effective 4/3/09; ARC 4910C, IAB 2/12/20, effective 3/18/20; ARC 5250C, IAB 11/4/20, effective 12/9/20]

191—48.3(508E) License requirements.

48.3(1) Viatical settlement provider.

a. To be considered for licensure as a viatical settlement provider pursuant to Iowa Code section 508E.3, a person must file with the commissioner a completed viatical settlement provider license application in the format prescribed by the commissioner, submit to a criminal history check pursuant to Iowa Code section 522B.5A, pay an application fee in the amount of \$100, and provide the following:

(1) Copies of the viatical settlement provider’s audited financial statements for the current year and each of the previous five years. At the commissioner’s discretion, the applicant also shall provide a copy of the current year’s consolidated annual audited financial statement with a financial guarantee from the provider’s ultimate controlling person, and copies of the provider’s unaudited financial statements for the current year and each of the previous five years;

(2) Evidence that the applicant maintains books and records in compliance with generally accepted accounting principles;

(3) If a legal entity intending to have any partners, officers, members, and designated employees act as viatical settlement providers or viatical settlement brokers under the legal entity’s license pursuant to Iowa Code section 508E.3, all completed forms, fees, and information required to be filed under subrule 48.3(2) for each such person named in the application and any supplements to the application;

(4) Biographical affidavits, in a form prescribed by the commissioner, for the following: officers and directors (as listed on the most recent financial statement), key managerial personnel (including any vice presidents or other individuals who will control the operations of the applicant), and individuals with a 10 percent or more beneficial ownership in the applicant who will exercise control over the applicant;

(5) An independent business character report on the individuals listed in subparagraph (4). The business character report shall be filed directly with the commissioner by the independent third party that certified the report. The business character report shall be in a format prescribed by the commissioner and shall not be older than one year prior to the date the application is filed. For purposes of this subparagraph, “business character report” means a statement certified by an independent third party which has conducted a comprehensive review of the applicant’s background and has indicated that the biographical information provided in the report, as completed by the applicant, has no inaccurate or conflicting information. An independent third party is one that has no affiliation with the applicant and is in the business of providing background checks or investigations. Business character reports must be current and shall not be older than one year prior to the date the application is filed. The business character report shall be in the format prescribed by the commissioner;

(6) Initial viatical settlement contracts, disclosure statements, and advertising material that have been or are being submitted for approval and that have been approved or that are approved during the course of the application process pursuant to Iowa Code section 508E.5;

(7) A copy of the provider trust, pursuant to 48.3(1) "c"; and

(8) A report of any civil, criminal or administrative actions taken or pending against the viatical settlement provider in any state or federal court or agency, regardless of outcome.

b. A form for the antifraud plan that is required to be submitted with an application pursuant to Iowa Code section 508E.3, to meet the requirements of Iowa Code section 508E.15, can be found on the division's website.

c. The provider trust that is required to be submitted with an application, pursuant to subparagraph 48.3(1) "a"(7), shall be in a format acceptable to the commissioner and shall include the following provisions:

(1) The provider trust cannot be terminated without the prior written consent of the commissioner.

(2) The provider trust is subject to the prior approval of the commissioner.

(3) The provider trust funds shall not be intermingled.

(4) The provider trust funds held shall be identified based on individual policyholders.

(5) The provider trust trustee is obligated to indemnify the provider or the policyholder or both for any lost funds.

(6) The agreement can only be amended or terminated with the prior written consent of the commissioner.

(7) The provider trust trustee shall be a bank or trust company, having its principal place of business in the United States.

(8) The provider trust trustee shall be audited annually by independent public accountants and complete the audit report, related financial statements, and opinion on internal controls. All reports shall be available for review by the commissioner.

d. In addition to the information required in this subrule, the commissioner may ask for other information necessary to determine whether the applicant for a license as a viatical settlement provider complies with the requirements of this subrule and Iowa Code subsection 508E.3(7).

48.3(2) Viatical settlement broker.

a. To be considered for licensure as a viatical settlement broker pursuant to Iowa Code section 508E.3, a person must file a completed viatical settlement broker license application in the format prescribed by the commissioner, pay an application fee in the amount of \$100, and submit to a criminal history check and pay the associated fee pursuant to Iowa Code section 522B.5A. In addition to finding compliance with Iowa Code section 508E.3, the commissioner also shall find that the applicant:

(1) Has provided proof of one of the following:

1. The applicant has taken and passed an examination on viatical and life settlement contracts required by another state insurance department and currently holds a license as a viatical settlement broker from that state; or

2. The applicant has passed the viatical settlement examination required by the commissioner. Examination results are valid for 90 days after the date of the examination. If the applicant fails to apply for licensure within 90 days after passing the examination, the examination results shall be void;

(2) Has provided a report of any civil, criminal or administrative actions taken or pending against the viatical settlement broker in any state or federal court or agency, regardless of outcome, excluding misdemeanor traffic citations and juvenile offenses; and

(3) Has provided proof that the applicant is covered by an errors and omissions policy for an amount of not less than \$100,000 liability per occurrence and not less than \$100,000 total annual aggregate for all claims during the policy period.

b. A form for the antifraud plan that is required to be submitted with an application pursuant to Iowa Code section 508E.3, to meet the requirements of Iowa Code section 508E.15, can be found on the division's website.

c. In addition to the information required in this subrule, the commissioner may ask for other information necessary to determine whether the applicant for a license as a viatical settlement broker

complies with the requirements of this subrule and has made a filing pursuant to Iowa Code subsection 508E.3(7).

48.3(3) *Governing law where viators are residents of different states.* For purposes of this subrule, if there is more than one viator on a single policy and the viators are residents of different states, the viatical settlement contract shall be governed by the law of the state in which the viator having the largest percentage ownership resides or, if the viators hold equal ownership, the state of residence of one viator agreed upon in writing by all viators. If another state does not have a statute or rule substantially similar to Iowa Code chapter 508E and this rule, the actions related to the viatical settlement contract shall be governed by the law of this state.

48.3(4) *License term.*

a. A viatical settlement provider or viatical settlement broker who meets the requirements of this rule, unless otherwise denied licensure pursuant to rule 191—48.10(508E), shall be issued a license.

b. A viatical settlement provider license is valid for three years and automatically terminates on the last day of the month of the anniversary of the issue date unless renewed pursuant to subrule 48.3(6).

c. A viatical settlement broker license is valid for an initial term of three years from the last day of the applicant's anniversary month following the issuance of the license, and automatically terminates on the last day of the month of the initial term unless renewed pursuant to subrule 48.3(6).

d. A viatical settlement provider license or a viatical settlement broker license may remain in effect for the term of the license plus any renewals, unless the license is revoked or suspended, as long as all required fees are paid in the time prescribed by the commissioner.

e. The license issued to a viatical settlement provider or viatical settlement broker shall be a limited license that allows the licensee to operate only within the scope of its license.

48.3(5) *Continuing education for viatical settlement broker.*

a. An individual licensed as a viatical settlement broker must complete 36 credits of approved continuing education during every license term. A license term is as set forth in paragraph 48.3(4) "c."

b. The required continuing education credits shall include a minimum of:

(1) Thirty-three credits related to life insurance, viatical settlements and viatical settlement transactions; and

(2) Three credits in ethics.

c. The viatical settlement broker may submit the same completed credits to the commissioner both to meet the continuing education requirements for the viatical settlement broker license and to meet the continuing education requirements for an applicable insurance producer license.

d. The license of a viatical settlement broker who fails to comply with this continuing education requirement will terminate.

e. An instructor of an approved continuing education course shall be granted the same credit as a student who completes the continuing education course, and the instructor may receive such credit once during a license term.

f. A viatical settlement broker cannot carry over excess continuing education credits from one license term to the next.

g. A viatical settlement broker may receive continuing education credit for self-study courses. A self-study course is considered completed when the continuing education provider receives the completed examination from the viatical settlement broker.

(1) A viatical settlement broker may receive continuing education credit for self-study courses that are part of a recognized national designation program as described in 191—subrule 11.5(5).

(2) A viatical settlement broker may receive continuing education credits for self-study courses that do not meet the requirement of subparagraph (1) if the viatical settlement broker:

1. Submits an affidavit to the continuing education provider that the examination was independently proctored and was completed without any outside assistance, and

2. Correctly answers at least 70 percent of the questions presented.

h. A viatical settlement broker shall not receive continuing education credit for courses taken prior to the issuance of an initial license.

i. A viatical settlement broker cannot receive continuing education credit for the same course twice in one license term. A viatical settlement broker cannot receive continuing education credit both for the classroom portion and for the examination portion of a national designation program as defined in 191—subrule 11.5(5).

j. A viatical settlement broker may elect to comply with the continuing education requirements by taking and passing the viatical settlement broker licensing examination within 90 days prior to the date on which the renewal application is submitted.

k. A viatical settlement broker shall demonstrate compliance with the continuing education requirements at the time of license renewal. A viatical settlement broker shall maintain a record of all continuing education courses completed by keeping the original certificates of completion for four years after the end of the year of course completion.

l. For purposes of rule 191—48.3(508E), “credit” means continuing education credit. One credit is 50 minutes of instruction or reading material in an acceptable topic.

m. Viatical settlement broker continuing education courses will be approved in the same manner that insurance continuing education courses are approved pursuant to 191—Chapter 11. The approval of continuing education providers, the responsibilities of continuing education providers, the prohibited conduct for continuing education providers, and the fees for approval and renewal of continuing education providers and courses shall be the same as those for insurance continuing education courses, continuing education providers, and insurance producers set forth in rules 191—11.9(505,522B) to 191—11.11(505,522B) and 191—11.14(505,522B). The commissioner may enter into a contractual arrangement with a qualified outside vendor to assist the commissioner with any or all continuing education services in the same manner as the commissioner may for insurance continuing education services pursuant to rule 191—11.12(505,522B). The commissioner may audit any continuing education course in the same manner as the commissioner may for insurance continuing education courses pursuant to rule 191—11.13(505,522B).

48.3(6) License renewal. A viatical settlement provider license or a viatical settlement broker license may be renewed as follows:

a. A viatical settlement provider license may be renewed by payment of \$100 within 90 days prior to the expiration date of the license and by demonstration that the viatical settlement provider continues to meet the requirements of Iowa Code section 508E.3 and subrule 48.3(1), has provided biographical affidavits not older than one year prior to the renewal date on all persons listed in subparagraph 48.3(1)“a”(4), has provided business character reports for any new persons listed in subparagraph 48.3(1)“a”(4), and has provided the reports required by rule 191—48.7(508E).

(1) If renewal is approved, the license will be renewed effective the last day of the month of the anniversary of the issue date in the renewal year, will be valid for three years, and will automatically terminate on the last day of the month of the anniversary of the issue date in the following renewal year unless renewed pursuant to this subrule.

(2) Viatical settlement providers that had licenses prior to January 1, 2009, shall have a renewal date of January 1.

b. A viatical settlement broker license may be renewed by demonstration of completion of continuing education as required in subrule 48.3(5) and payment of \$100 within 90 days prior to the expiration date of the license. If renewal is approved, the license will be renewed effective the last day of the month of the anniversary of the issue date in the renewal year, will be valid for three years, and will automatically terminate on the last day of the month of the anniversary of the issue date in the following renewal year unless renewed pursuant to this subrule.

c. If a legal entity has any partners, officers, members, or designated employees acting as viatical settlement providers or viatical settlement brokers under the legal entity’s license pursuant to Iowa Code section 508E.3, the legal entity must provide all completed forms, fees, and information required to be filed under paragraphs 48.3(6)“a” and “b” for each such person named in the application, or in any supplements to the application, and must provide any deletions to the list of names that was provided with the original application. If there are any new partners, officers, members, and designated employees that the legal entity intends will act as viatical settlement providers or viatical settlement brokers under

the legal entity's license, the legal entity shall provide for each such person the forms, information and fees required by subrule 48.3(2).

d. If a viatical settlement provider or viatical settlement broker fails to comply with the renewal procedures within the time prescribed, or a viatical settlement provider fails either to meet the requirements of Iowa Code section 508E.3 and subrule 48.3(1) or to submit the reports required in rule 191—48.7(508E), such nonpayment or failure shall result in lapse of the license.

e. A licensed viatical settlement broker who is unable to comply with license renewal procedures due to military service or some other extenuating circumstance may request from the commissioner a waiver of renewal procedures. Such viatical settlement broker may also request a waiver of any examination requirement or any other penalty or sanction imposed for failure to comply with renewal procedures.

48.3(7) *License reinstatement.*

a. A viatical settlement broker may reinstate an expired license up to 12 months after the license expiration date by proving that during the license term the viatical settlement broker met the CE requirements found in subrule 48.3(5), and by paying to the commissioner a reinstatement fee and license renewal fee. A viatical settlement broker who fails to apply for license reinstatement within 12 months of the license expiration date must apply for a new license.

b. A viatical settlement broker who has surrendered a license for a nondisciplinary reason and stated an intent to exit the viatical settlement business may file a request to reactivate the license. The request must be received by the commissioner within 90 days of the date the license was placed on inactive status. The request will be granted if the former viatical settlement broker is otherwise eligible to receive the license. If the request is not received within 90 days, the viatical settlement broker must apply for a new license.

48.3(8) *Reinstatement or reissuance of a license after suspension, revocation or forfeiture in connection with disciplinary matters; and forfeiture in lieu of compliance.*

a. The term “reinstatement” as used in this subrule means the reinstatement of a suspended license. The term “reissuance” as used in this subrule means the issuance of a new license following either the revocation of a license, the suspension and subsequent termination of a license, or the forfeiture of a license in connection with a disciplinary matter. This subrule does not apply to the reinstatement of an expired license or the issuance of a new license after the reinstatement period has passed that is not in connection with a disciplinary matter.

b. Any viatical settlement broker whose license has been revoked or suspended by order, or who forfeited a license in connection with a disciplinary matter, must apply to the commissioner for reinstatement or reissuance in accordance with the terms of the order of revocation or suspension or the order accepting the forfeiture.

(1) All proceedings for reinstatement or reissuance shall be initiated by the applicant who shall file with the commissioner an application for reinstatement or reissuance of a license. As part of the application, the applicant shall submit to a criminal history check pursuant to Iowa Code section 522B.5A.

(2) An application for reinstatement or reissuance shall allege facts which, if established, will be sufficient to enable the commissioner to determine that the basis of revocation, suspension or forfeiture of the applicant's license no longer exists and that it will be in the public interest for the application to be granted. The burden of proof to establish such facts shall be on the applicant.

(3) A viatical settlement broker may request reinstatement of a suspended license prior to the end of the suspension term; however, reinstatement will not be effected until the suspension period has ended.

(4) Unless otherwise provided by law, if the order of revocation or suspension did not establish terms upon which reinstatement or reissuance may occur, or if the license was forfeited, an initial application for reinstatement or reissuance may not be made until at least one year has elapsed from the date of the order of the suspension (notwithstanding 191—paragraph 10.10(2)“e”), revocation, or acceptance of the forfeiture of a license.

c. All proceedings upon the application for reinstatement or reissuance, including matters preliminary and ancillary thereto, shall be held in accordance with Iowa Code chapter 17A. Such

application shall be docketed in the original case in which the license was suspended, revoked, or forfeited, if a case exists.

d. An order of reinstatement or reissuance must be a written decision that incorporates findings of fact and conclusions of law. An order granting an application for reinstatement or reissuance may impose such terms and conditions as the commissioner or the commissioner's designee deems appropriate, which may include one or more of the types of disciplinary sanctions provided by this chapter or by Iowa Code chapter 508E. The order is a public record and may be disseminated in accordance with Iowa Code chapter 22.

e. A submission of voluntary forfeiture of a license must be made in writing in the format prescribed by the commissioner. Forfeiture of a license is effective upon the submission unless a contested case proceeding is pending at the time of the submission. If a contested case proceeding is pending, the forfeiture becomes effective when and upon such conditions as required by order of the commissioner. A forfeiture made during the pendency of a contested case proceeding is considered a disciplinary action and must be published in the same manner as is applicable to any other form of disciplinary order.

f. A license may be voluntarily forfeited in lieu of compliance with an order of the commissioner or the commissioner's designee with the written consent of the commissioner. The forfeiture becomes effective when and upon such conditions as required by order of the commissioner, which may include one or more of the types of disciplinary sanctions provided by this chapter or by Iowa Code chapter 508E.

g. When a viatical settlement broker's license has been suspended for a period of time that extends beyond the viatical settlement broker's license expiration date, the license terminates at the license expiration date, and the viatical settlement broker must request reissuance pursuant to this subrule. However, reissuance will not be effected until the suspension period has ended. If suspension for a period of time ends prior to the viatical settlement broker's license expiration date, and the viatical settlement broker has met all applicable requirements, the commissioner must reinstate the license as soon as practicable but no earlier than the end of the suspension period pursuant to paragraph 48.3(8) "b." The commissioner is not prohibited from denying an application for reinstatement or reissuance or bringing an additional immediate action if the viatical settlement broker has engaged in misconduct during the period of suspension.

48.3(9) *Duty to notify commissioner of cessation of business in the state.* If a viatical settlement provider intends to cease business in Iowa, it must notify the commissioner of those intentions and of its plan of operation for such cessation at least 180 days before the cessation shall occur. This requirement is not meant to imply that a company must continue to accept new viatical or life settlement business during the 180-day period.

48.3(10) *Duty to notify commissioner of changes.*

a. A viatical settlement provider shall provide to the commissioner any new or revised information about officers, stockholders holding 10 percent or more of the stock of the company, partners, directors, members or designated employees within 30 days of the date the addition or revision occurred.

b. A viatical settlement provider or viatical settlement broker shall inform the commissioner in writing of any change of name or address within 30 days of the date of such change. In addition, a viatical settlement provider shall provide the commissioner with 30 days' notice of the cancellation or nonrenewal of a fidelity bond required for licensure under subrule 48.3(1) and the name of the carrier that will be providing coverage subsequent to such cancellation or nonrenewal.

c. A viatical settlement provider or viatical settlement broker shall report to the commissioner any administrative action taken against the viatical settlement provider or viatical settlement broker in another state or federal jurisdiction or by another governmental agency in this state within 30 days of the final disposition of the matter. This report shall include a copy of the order, consent to the order, or other relevant legal documents. Within 30 days of the initial pretrial hearing date, a viatical settlement provider or viatical settlement broker shall report to the commissioner any criminal prosecution of the viatical settlement provider or viatical settlement broker taken in any jurisdiction. The report shall include a

copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

48.3(11) Commissioner may use outside assistance. In order to assist with the commissioner's duties, the commissioner may contract with a nongovernmental entity, including, but not limited to, the National Association of Insurance Commissioners (NAIC) or any affiliate or subsidiary the NAIC oversees, to perform any ministerial functions related to licensing of viatical settlement providers or viatical settlement brokers that the commissioner deems appropriate including, but not limited to, the collection of fees.

48.3(12) Fees.

- a. Fees shall be paid by check, money order, or credit card.
- b. The fee for an examination may be set by the outside testing service under contract with the division and must be approved by the division.
- c. The fee for issuance or renewal of a viatical broker, legal entity or provider license is \$100.
- d. The fee for reinstatement or reissuance of a viatical broker, legal entity or provider license is \$100. In addition, applicable issuance or renewal fees will be assessed.
- e. The division may charge a reasonable fee for the compilation and production of viatical broker, legal entity or provider licensing records.
- f. The fee for a criminal history check as required pursuant to Iowa Code section 522B.5A is \$50. [ARC 7729B, IAB 4/22/09, effective 4/3/09; ARC 4910C, IAB 2/12/20, effective 3/18/20; ARC 5250C, IAB 11/4/20, effective 12/9/20; ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—48.4(508E) Disclosure statements.

48.4(1) If a viatical settlement provider enters into a viatical settlement contract that allows the viator to retain an interest in the policy, the viatical settlement contract shall contain the following:

- a. A provision that the viatical settlement provider will effect the transfer of the amount of the death benefit only to the extent or portion of the amount viaticated and that benefits in excess of the amount viaticated shall be paid directly to the viator's beneficiary by the insurance company;
- b. A provision that the viatical settlement provider will, upon acknowledgment of the perfection of the transfer, either:
 - (1) Advise the insured, in writing, that the insurance company has confirmed the viator's interest in the policy; or
 - (2) Send to the insured a copy of the document(s) sent from the insurance company to the viatical settlement provider that acknowledges the viator's interest in the policy; and
- c. A provision that apportions the premiums to be paid by the viatical settlement provider and the viator. It is permissible for the viatical settlement contract to specify that all premiums shall be paid by the viatical settlement provider. The viatical settlement contract also may require that the viator reimburse the viatical settlement provider only for the premiums attributable to the retained interest.

48.4(2) With each application for a viatical settlement contract, a viatical settlement provider or viatical settlement broker shall provide the viator with at least the following disclosure no later than the time the application for the viatical settlement contract is signed by the viator and the viatical settlement broker. The disclosure shall be provided in a separate document that is signed by the viator and the viatical settlement provider or viatical settlement broker, and shall advise the viator that, when entering into a viatical settlement contract, having a recent physical examination is in the viator's best interest, since an accurate life expectancy can be best calculated based on current medical records.

48.4(3) If the viator is not the insured, then these disclosures must be affirmatively made to the insured, as well as to the viator, and written consent to the viatication must be received from both parties.

191—48.5(508E) Contract requirements. In order to ensure that viators receive a reasonable return for viaticating an insurance policy when life expectancy is less than 25 months, a viatical settlement provider shall pay to a viator a discounted amount of the face value of the policy which amount shall be calculated at least at the following rates:

Insured's Life Expectancy	Minimum Percentage of Face Value Less Outstanding Loans Received by Viator
Less than 6 months	80%
At least 6 but less than 12 months	70%
At least 12 but less than 18 months	65%
At least 18 but less than 25 months	60%
25 months or more	Cash surrender value of policy

The percentage may be reduced by 5% for viaticating a policy written by an insurer rated less than the highest four categories by A.M. Best, or a comparable rating by another rating agency.

For a viatical settlement in which the viator has a life expectancy of 25 months or more, a viatical settlement provider or broker shall not enter into a viatical settlement contract that provides a payment to the viator that is unreasonable or unjust. As listed above, such payment must at least be equal to the cash surrender value of the policy. In determining whether a payment is unreasonable or unjust, the commissioner may consider, among other factors, the life expectancy of the insured; the applicable rating of the insurance company that issued the subject policy by a rating service generally recognized by the insurance industry, regulators and consumer groups; and prevailing discount rates in the viatical and life settlement market in Iowa or, if insufficient data is available for Iowa, the prevailing rates nationally or in other states that maintain this data.

191—48.6(508E) Filing of forms. If a viatical settlement provider subsequently desires to change the viatical settlement contract documents or disclosure statements approved at the time of licensure, or to use new ones, the provider shall submit the new or modified contract documents or disclosure statements to the commissioner for approval in triplicate, along with a postage-paid return envelope. The viatical settlement provider shall identify its name and address in the cover letter and also reference the form number of the modified viatical settlement contract document or disclosure statement. Black-lining the modifications made within the document(s) should expedite the form review and approval process.

191—48.7(508E) Reporting requirements.

48.7(1) On March 1 of each calendar year, the secretary and either the president or the vice president of each viatical settlement provider licensed in this state shall submit, under oath, the following: the annual statement required by Iowa Code section 508E.6; a report of all viatical settlement transactions in which the viator is a resident of this state; and a report for all states in the aggregate. The report shall contain the following information for the previous calendar year:

- a. For viatical settlements contracted during the reporting period:
 - (1) Date of viatical settlement contract;
 - (2) Viator's state of residence at the time of the contract;
 - (3) Mean life expectancy, in months, of the insured at time of contract;
 - (4) Face amount of policy viaticated;
 - (5) Net death benefit viaticated;
 - (6) Estimated total premiums to keep policy in force for mean life expectancy;
 - (7) Net amount paid to viator;
 - (8) Source of policy (B-Broker; D-Direct Purchase; SM-Secondary Market);
 - (9) Type of coverage (I-Individual; G-Group);
 - (10) Within the contestable or suicide period, or both, at the time of viatical settlement (yes or no);
 - (11) If the insured is diagnosed as terminally or chronically ill, the general disease classification applicable to such insured; and
 - (12) Type of funding (I-Institutional; P-Private).
- b. For viatical settlements in which death of the insured has occurred during the reporting period:
 - (1) Date of viatical settlement contract;

- (2) Viator's state of residence at the time of the contract;
- (3) Mean life expectancy, in months, of the insured at time of contract;
- (4) Net death benefit collected;
- (5) Total premiums paid to maintain the policy (WP-Waiver of Premium; NA-Not Applicable);
- (6) Net amount paid to viator;
- (7) If the insured was diagnosed as terminally or chronically ill, the general disease classification applicable to such insured;
- (8) Date of death of insured;
- (9) Amount of time, in months, between date of contract and date of death of insured;
- (10) Difference between the number of months that passed between the date of contract and the date of death of insured and the mean life expectancy in months as determined by the reporting company;
- c. Name and address of each viatical settlement broker through whom the reporting company purchased a policy from a viator who resided in this state at the time of contract;
- d. Number of policies reviewed and rejected; and
- e. Number of policies purchased from persons other than a viator (on the secondary market) as a percentage of total policies purchased.

48.7(2) On or before March 1 of each year, the secretary and either the president or the vice president of each viatical settlement provider licensed in this state shall make a report under oath of the following or shall provide the following documentation:

- a. That the viatical settlement provider has at all times maintained books and records in compliance with generally accepted accounting principles;
- b. That the viatical settlement provider has obtained and furnished to the commissioner either:
 - (1) A copy of the current year's audited financial statement; or
 - (2) At the commissioner's discretion, a copy of the current year's consolidated annual audited financial statement with a financial guarantee from the provider's ultimate controlling person; and
- c. That the viatical settlement provider has maintained fidelity bonds on each officer and director in the amount of \$100,000.

[ARC 7729B, IAB 4/22/09, effective 4/3/09]

191—48.8(508E) Examination or investigations.

48.8(1) *Authority, scope and scheduling of examinations.* In addition to the authority, scope and scheduling of examinations set forth in Iowa Code section 508E.7, the following provisions shall apply:

- a. The commissioner may investigate suspected fraudulent viatical settlement acts and persons engaged in the business of viatical settlements.
- b. The provisions of Iowa Code chapter 507 shall apply to viatical settlement providers and viatical settlement brokers. The expense of examinations shall be assessed against the viatical settlement provider in the same manner as insurers are assessed for examinations.
- c. Neither the commissioner nor any person that received the documents, material or other information while acting under the authority of the commissioner, including the NAIC and its affiliates and subsidiaries, shall be permitted to testify in any private civil action concerning any confidential documents, materials or information subject to this subrule.

48.8(2) *Immunity from liability.* No cause of action shall arise nor shall any liability be imposed against the commissioner, the commissioner's authorized representatives or any examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this rule or of Iowa Code chapter 508E.

[ARC 7729B, IAB 4/22/09, effective 4/3/09]

191—48.9(508E) Requirements and prohibitions.

48.9(1) With respect to policies containing a provision for double or additional indemnity for accidental death, the additional payment shall remain payable to the beneficiary last named by the viator prior to entering into the viatical settlement contract, or to such other beneficiary, other than the viatical settlement provider, as the viator may thereafter designate, or in the absence of a beneficiary, to the estate of the viator.

48.9(2) Payment of the proceeds to the viator pursuant to a viatical settlement contract shall be made in a lump sum except where the viatical settlement provider has purchased a single-premium paid-up annuity issued by a licensed insurance company to the viator. Retention of a portion of the proceeds by the viatical settlement provider or escrow agent is not permissible. For purposes of this subrule, “escrow agent” means an individual or institution that has established an escrow or trust account with a state-chartered or federally chartered financial institution whose deposits and accounts are insured by the Federal Deposit Insurance Corporation (FDIC) and with which an escrow account has been established for use by a viatical settlement provider or viatical settlement purchaser.

48.9(3) If a viatical settlement provider or viatical settlement broker is served with a subpoena and thereby compelled to produce records containing patient-identifying information, the viatical settlement provider or viatical settlement broker shall notify the viator and the insured in writing at the viator’s and the insured’s last-known addresses within five business days after receiving notice of the subpoena.

48.9(4) A viatical settlement provider shall not act also as a viatical settlement broker, whether entitled to collect a fee directly or indirectly, related to the same viatical settlement contract.

48.9(5) A viatical settlement broker shall not, without the written agreement of the viator obtained prior to performing any services in connection with a viatical settlement, seek or obtain any compensation from the viator.

48.9(6) A viatical settlement provider shall not use a longer life expectancy than is reasonable based on all medical and actuarial information available at the time of a viatical settlement transaction in order to reduce the payout to which the viator is entitled.

48.9(7) A viatical settlement provider or viatical settlement broker shall not discriminate in the making or solicitation of viatical settlement contracts on the basis of race, age, sex, national origin, creed, religion, occupation, marital or family status or sexual orientation, or discriminate between viators with or without dependents.

48.9(8) A viatical settlement provider or viatical settlement broker shall not pay or offer to pay any finder’s fee, commission or other compensation to any insured’s physician, or to an attorney, accountant or other person providing medical, legal or financial planning services to an insured or viator, or to any other person acting as an agent of an insured or viator with respect to a viatical settlement contract.

48.9(9) A viatical settlement provider shall not knowingly solicit individuals who have treated or have been asked to treat the illness of an insured whose coverage would be the subject of a viatical settlement contract.

48.9(10) A life insurance company may not charge a fee for responding to a request for information from a viatical settlement provider or viatical settlement broker in compliance with this rule in excess of any usual and customary charges to contract holders, certificate holders or insureds for similar services.

48.9(11) In recommending a viatical settlement contract, viatical settlement brokers and viatical settlement providers shall make suitable recommendations.

191—48.10(508E) Penalties; injunctions; civil remedies; cease and desist.

48.10(1) Unfair trade practices. Pursuant to Iowa Code section 508E.17, a violation of rule 191—48.4(508E), 191—48.5(508E), 191—48.6(508E), 191—48.7(508E) or 191—48.9(508E) shall be considered an unfair trade practice under Iowa Code chapter 507B, and a violator shall be subject to the penalties contained in that chapter.

48.10(2) Unauthorized insurer. A person doing the activities of a viatical settlement provider or a viatical settlement broker without a license under this chapter shall be deemed an unauthorized insurer and shall be subject to the penalties of Iowa Code chapter 507A.

48.10(3) License revocation and denial. The commissioner may suspend, revoke, refuse to issue, or refuse to renew the license of a viatical settlement provider or viatical settlement broker for violation of rule 48.3(508E).

48.10(4) A viatical settlement provider licensed in this state that in the time required fails to file either the annual statement referred to in Iowa Code section 508E.6 or the annual audited financial statement referred to in subparagraph 48.3(1)“a”(1) shall pay an administrative penalty pursuant to Iowa Code

section 508E.16. The viatical settlement provider's right to transact further new business in this state shall immediately cease until the provider has fully complied with this rule.

48.10(5) Pursuant to Iowa Code section 508E.16, if the commissioner finds that an activity in violation of this rule presents an immediate danger to the public that requires an immediate final order, the commissioner may issue an emergency cease and desist order reciting with particularity the facts underlying the findings. The emergency cease and desist order is effective immediately upon service of a copy of the order on the respondent and remains in effect for 90 days. If the commissioner begins nonemergency cease and desist proceedings, the emergency cease and desist order remains effective, absent an order by a court of competent jurisdiction pursuant to 191—Chapters 2 and 3.

[ARC 7729B, IAB 4/22/09, effective 4/3/09; ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—48.11(252J,272D) Suspension for failure to pay child support or state debt. The division must follow the procedures in rule 191—10.21(252J,272D) relating to producer suspension for failure to pay child support or state debt for viatical settlement brokers, replacing “producer” with “viatical settlement broker.”

[ARC 4910C, IAB 2/12/20, effective 3/18/20]

191—48.12(261) Suspension for failure to pay student loan. Rescinded ARC 4910C, IAB 2/12/20, effective 3/18/20.

191—48.13(272D) Suspension for failure to pay state debt. Rescinded ARC 4910C, IAB 2/12/20, effective 3/18/20.

191—48.14(508E) Severability. If any rule or portion of a rule or its applicability to any person or circumstance is held invalid by a court, the remainder of these rules or the rules' applicability to other persons or circumstances shall not be affected.

[ARC 7729B, IAB 4/22/09, effective 4/3/09]

These rules are intended to implement Iowa Code chapters 508E, 252J, and 272D.

[Filed 12/7/01, Notice 10/17/01—published 12/26/01, effective 2/1/02]

[Filed 11/2/06, Notice 9/27/06—published 11/22/06, effective 12/27/06]

[Filed emergency 8/20/08—published 9/10/08, effective 8/20/08]

[Filed 10/16/08, Notice 9/10/08—published 11/5/08, effective 12/10/08]

[Filed Emergency ARC 7729B, IAB 4/22/09, effective 4/3/09]

[Filed ARC 4910C (Notice ARC 4821C, IAB 12/18/19), IAB 2/12/20, effective 3/18/20]

[Filed ARC 5250C (Notice ARC 5129C, IAB 8/12/20), IAB 11/4/20, effective 12/9/20]

[Filed ARC 5515C (Notice ARC 5389C, IAB 1/13/21), IAB 3/10/21, effective 4/14/21]

CHAPTER 99
LIMITED PURPOSE SUBSIDIARY LIFE INSURANCE COMPANIES

191—99.1(505,508) Authority. This chapter is promulgated by the commissioner of insurance pursuant to Iowa Code sections 505.8 and 508.33A.

[ARC 9229B, IAB 11/17/10, effective 12/22/10; ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—99.2(505,508) Purpose. The purpose of this chapter is to authorize the establishment of domestic limited purpose subsidiary life insurance companies that are wholly owned by domestic insurers authorized to transact the business of insurance pursuant to Iowa Code chapter 508 and that may issue securities and otherwise access financial markets and alternative sources of capital through securitizations and other transactions.

[ARC 9229B, IAB 11/17/10, effective 12/22/10]

191—99.3(505,508) Definitions. For purposes of this chapter, the following definitions shall apply:

“*Affiliated companies*” means domestic life insurance companies that are directly or indirectly wholly owned subsidiaries of the same parent.

“*Ceding insurer*” means a domestic life insurance company that is an affiliated company of an LPS and that cedes risk to the LPS pursuant to a reinsurance contract.

“*Commissioner*” means the Iowa insurance commissioner.

“*Guaranty of a parent*” means an agreement to pay specified obligations of the LPS by a parent of the LPS approved by the commissioner that is not a ceding insurer and the guarantor has sufficient equity, less the equity of all ceding insurers that are subsidiaries of the guarantor, to satisfy the agreement during the life of the guaranty.

“*Insurance securitization*” or “*securitization*” means a transaction or a group of related transactions, which may include capital market offerings, that are effected through related risk transfer instruments and facilitating administrative agreements where all or part of the result of such transactions is used to fund the LPS’s obligations under a reinsurance contract with a ceding insurer and by which proceeds are:

1. Obtained by an LPS, directly or indirectly, through the issuance of securities by the LPS or any other person; or

2. Provided through one or more letters of credit or other assets for the benefit of the LPS, which the commissioner authorizes the LPS to treat as admitted assets for purposes of the LPS’s annual statement; where all or any part of such proceeds, letters of credit, or assets, as applicable, is used to fund the LPS’s obligations under a reinsurance contract with a ceding insurer. The terms “insurance securitization” and “securitization” do not include the issuance of a letter of credit for the benefit of the commissioner to satisfy all or part of the LPS’s capital and surplus requirements under this chapter.

“*Insurer*,” for purposes of this chapter, means a domestic life insurance company organized under Iowa Code chapter 508.

“*Letters of credit*” means clean, unconditional, irrevocable letters of credit issued or confirmed by a qualified United States financial institution as defined in Iowa Code section 521B.103(2) “c.”

“*LPS*” means a limited purpose subsidiary life insurance company organized pursuant to Iowa Code section 508.33A that is wholly owned by the organizing life insurance company and that is issued a certificate of authority by the commissioner pursuant to this chapter.

“*LPS security*” means:

1. A security issued by an LPS; or
2. A security issued by a third party, the proceeds of which are obtained directly or indirectly by an LPS.

“*Management*” means the board of directors, managing board, or other individual or individuals vested with overall responsibility for the management of the affairs of the LPS, including but not limited to officers or other agents elected or appointed to act on behalf of the LPS.

“*Material*” means a transaction or series of transactions involving amounts equal to or exceeding 3 percent of the LPS’s admitted assets less any letters of credit and intangible assets included as an admitted asset of the LPS.

“*Organizational document*” means an LPS’s articles of incorporation and bylaws.

“*Organizing life insurance company*” means the domestic life insurance company that organizes the LPS pursuant to Iowa Code section 508.33A.

“*Parent*” means a person as defined in Iowa Code section 521A.1 that directly or indirectly through one or more intermediaries wholly owns an LPS.

“*Reinsurance contract*” means a contract between an LPS and a ceding insurer pursuant to which the LPS agrees to provide reinsurance to the ceding insurer for risks.

“*Risk*” means risks associated with life insurance policies and contracts written by the ceding insurer or assumed by the ceding insurer from an affiliated company which were written by the affiliated company and for which the ceding insurer holds direct statutory reserves for those policies and contracts required by Iowa Code section 508.36.

“*Risk-based capital instructions*” means the instructions included in the risk-based capital report as adopted by the National Association of Insurance Commissioners, as such risk-based capital instructions may be amended by the National Association of Insurance Commissioners from time to time in accordance with the procedures adopted by the National Association of Insurance Commissioners.

“*Security*” means the same as defined in Iowa Code section 502.102 and shall also include any form of debt obligation, surplus note, derivative, or other financial instrument that the commissioner designates as a “security” for purposes of this chapter.

“*Subsidiary*” means the same as defined in Iowa Code section 521A.1(9).

“*Surplus note*” means an unsecured subordinated debt obligation possessing characteristics consistent with paragraph 3 of the National Association of Insurance Commissioners (NAIC) Statement of Statutory Accounting Principles No. 41, as amended from time to time and as modified or supplemented by rule or order of the commissioner.

[ARC 9229B, IAB 11/17/10, effective 12/22/10; ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—99.4(505,508) Formation of LPS.

99.4(1) An LPS’s organizational documents shall limit the LPS’s authority to transact the business of reinsurance to reinsure only the risks of a ceding insurer and shall state that the LPS shall not otherwise engage in the business of insurance.

99.4(2) An LPS’s organizational documents shall provide that the LPS shall always be wholly owned by the organizing life insurance company and that the LPS’s stock shall be issued only to the organizing life insurance company.

[ARC 9229B, IAB 11/17/10, effective 12/22/10]

191—99.5(505,508) Certificate of authority.

99.5(1) *Certificate of authority required.* No LPS shall do any reinsurance business in this state unless it obtains from the commissioner a certificate of authority pursuant to this rule.

99.5(2) *Application for certificate of authority.* Before receiving a certificate of authority, an LPS shall do all of the following:

a. File with the commissioner a copy of its plan of operation.
b. File with the commissioner an affidavit of its president, a vice president, the treasurer, or the chief financial officer that includes all of the following statements, to the best of such person’s knowledge and belief, after reasonable inquiry:

(1) The proposed organization and operation of the LPS comply with all applicable provisions of this chapter.

(2) The LPS’s investment policy reflects and takes into account the liquidity of assets and the reasonable preservation, administration, and management of such assets with respect to the risks associated with the reinsurance contract.

(3) Any reinsurance contract and any arrangement for securing the LPS’s obligations under such reinsurance contract, including but not limited to any agreements or other documentation to implement such arrangement, comply with the provisions of this chapter.

c. File with the commissioner an opinion of legal counsel, in a form acceptable to the commissioner, that the offer and sale of any LPS securities comply with all applicable registration

requirements or applicable exemptions from or exceptions to such requirements of the federal securities laws and that the offer and sale of securities by the LPS itself comply with all registration requirements or applicable exemptions from or exceptions to such requirements of the securities laws of this state. Such opinions shall not be required as part of the application if the LPS includes a specific statement in its plan of operation that such opinions will be provided to the commissioner in advance of the offer or sale of any LPS securities.

d. File with the commissioner an opinion of a qualified independent actuary acceptable to the commissioner that the methodology and assumptions to set and discount reserves make good and sufficient provision for the risk assumed by the LPS, including significant stress tests on key assumptions.

e. Pay to the commissioner the reasonable expenses and costs incurred by the commissioner incident to examining the LPS's application pursuant to Iowa Code chapter 507.

f. Submit any other statements or documents required by the commissioner to evaluate the LPS's application for a certificate of authority.

99.5(3) *Material change in application.* In the event of any material change in any item required in subrule 99.5(2), the LPS shall notify the commissioner at least 30 days prior to the change and submit to the commissioner for approval any revised documents, opinions, or certifications.

99.5(4) *Grant of certificate of authority.*

a. The commissioner may grant a certificate of authority to an LPS, which shall be valid through the next June 1 following the date of initial issuance and which may be renewed annually thereafter, authorizing the LPS to transact reinsurance business as an LPS in this state upon a finding that:

- (1) The proposed plan of operation provides for a viable operation;
- (2) The terms of any reinsurance contract and related transactions comply with this chapter and all applicable insurance laws and regulations; and
- (3) The proposed plan of operation is not hazardous to any ceding insurer.

b. In conjunction with the issuance of a certificate of authority to an LPS, the commissioner may issue an order that includes any provisions, terms, and conditions regarding the organization, licensing, and operation of the LPS that the commissioner deems appropriate and that are not inconsistent with the provisions of this chapter.

99.5(5) *Scope of certificate of authority.* An LPS issued a certificate of authority may reinsure only the risks of a ceding insurer. An LPS shall not otherwise engage in the business of insurance. An LPS may purchase reinsurance to cede the risks assumed under a reinsurance contract, subject to the prior approval of the commissioner.

[ARC 9229B, IAB 11/17/10, effective 12/22/10]

191—99.6(505,508) Capital and surplus.

99.6(1) An LPS shall not be issued a certificate of authority unless it possesses and thereafter maintains unimpaired paid-in capital and surplus of not less than \$2.5 million.

99.6(2) The commissioner may prescribe additional tangible capital and surplus based upon the type, volume, and nature of reinsurance business transacted.

99.6(3) Minimum capital and surplus required by subrule 99.6(1) shall be in the form of cash or other securities that are investment grade at the time of acquisition and acceptable to the commissioner.

[ARC 9229B, IAB 11/17/10, effective 12/22/10]

191—99.7(505,508) Plan of operation.

99.7(1) An LPS shall have a plan of operation approved by its board of directors. The plan of operation shall include all of the following:

- a.* A complete description of all reinsurance transactions, reinsurance security arrangements, securitizations, and any other material transactions or arrangements.
- b.* The source and form of the LPS's capital and surplus.
- c.* The investment policy of the LPS.

d. Pro forma balance sheets and income statements illustrating one or more adverse case scenarios, as determined under criteria required by the commissioner, for the performance of the LPS under all reinsurance contracts.

e. Risk-based capital requirements, which, at a minimum, shall require the LPS to maintain risk-based capital equal to the product of two and one-half and the number determined under the life risk-based capital formula in accordance with the risk-based capital instructions.

f. Notice and reporting of material transactions.

g. Policies for payments of dividends and other distributions to the organizing life insurance company.

h. Copies of all contracts between the LPS and affiliated companies.

99.7(2) Any change in the LPS's plan of operation shall require prior approval of the commissioner.
[ARC 9229B, IAB 11/17/10, effective 12/22/10]

191—99.8(505,508) Dividends and distributions. An LPS may pay dividends and distributions that do not decrease the capital of the LPS below the minimum capital and surplus amount designated by the commissioner pursuant to rule 191—99.6(505,508), provided, however, that no dividend or distribution may be declared or paid by an LPS if such dividend or distribution would jeopardize the ability of the LPS to fulfill the LPS's obligations. The LPS shall give the commissioner 30 days' prior notice of any dividend or distribution. The notice shall include the amount of the dividend or distribution and a certification signed by an officer of the LPS stating that the dividend or distribution would not jeopardize the ability of the LPS to fulfill the LPS's obligations.

[ARC 9229B, IAB 11/17/10, effective 12/22/10]

191—99.9(505,508) Reports and notifications.

99.9(1) Notice of securitizations. An LPS shall provide the commissioner with a copy of a complete set of executed documentation of an insurance securitization no later than 45 days after the closing on the transactions for such securitization.

99.9(2) Notice of material change to financial condition. In the event of any material change in the financial condition or management of an LPS, the LPS shall notify the commissioner in writing within two business days of any such change.

99.9(3) Reports on reserves. An LPS shall file annually with the commissioner an actuarial opinion, in compliance with 191—5.34(508), on reserves for all risks assumed by the LPS pursuant to its reinsurance contracts provided by an internal actuary and may discount its reserves in accordance with that actuarial opinion, subject to approval by the commissioner. An LPS shall file biennially an opinion of a qualified independent actuary acceptable to the commissioner concerning the methods and assumptions used to set reserves.

99.9(4) Risk-based capital reports. An LPS shall file annually with the commissioner a report of the LPS's risk-based capital level as of the end of the calendar year immediately preceding containing the information required by the risk-based capital instructions.

99.9(5) Foreclosure on collateral. An LPS shall notify the commissioner immediately of any action by a ceding insurer or any other person to foreclose on or otherwise take possession of collateral provided by the LPS to secure any obligation of the LPS.

99.9(6) Filing reports with the National Association of Insurance Commissioners. Notwithstanding 191—5.3(507,508,515), 191—5.26(508,515), or any other rule, an LPS shall not be required to file any report, notice, or other document with the National Association of Insurance Commissioners unless required by the commissioner.

[ARC 9229B, IAB 11/17/10, effective 12/22/10]

191—99.10(505,508) Material transactions.

99.10(1) Notice of material transactions. An LPS shall not take any of the following actions unless the LPS provides the commissioner at least 30 days' prior written notice and the commissioner expressly approves the action:

a. The dissolution of the LPS.

- b. Any sale, exchange, lease, mortgage, assignment, pledge or other transfer or granting of a security interest in over 30 percent of the assets of the LPS.
- c. Any incurrence of material indebtedness by the LPS.
- d. Any making of a material loan or other material extension of credit by the LPS.
- e. Any material payment out of capital and surplus other than dividends or distributions paid in accordance with rule 191—99.8(505,508).
- f. Any merger or consolidation to which the LPS is a constituent party.
- g. Any transfer to or redomestication in any jurisdiction by the LPS.
- h. The termination of all or any part of an LPS's business.

This subrule shall not apply when an LPS takes any action described in paragraph “b” or “e” in accordance with the LPS's plan of operation.

99.10(2) *Prior approval of certain payments.* An LPS shall submit for prior approval of the commissioner periodic written requests for authorization to make payments of interest on and repayments of principal of surplus notes and other debt obligations issued by the LPS, provided that the commissioner shall not approve such payment if the commissioner determines that such payment would jeopardize the ability of the LPS or any other person to fulfill the person's respective obligations. [ARC 9229B, IAB 11/17/10, effective 12/22/10]

191—99.11(505,508) Investments.

99.11(1) *Administration of assets.* The investment program developed by an LPS shall take into account the safety of the company's assets, investment yield and return, stability in the value of the investment, and liquidity necessary to meet the company's expected business needs and investment diversification. The assets of an LPS shall be preserved and administered by or on behalf of the LPS to satisfy the liabilities and obligations of the LPS incident to the reinsurance contract, the insurance securitization, and other related agreements. For the purposes of this subrule, assets do not include letters of credit and guaranties of a parent. An LPS shall only invest its assets in cash and securities that are investment grade at the time of acquisition, provided, however, that an LPS may invest up to 10 percent of its assets in securities or other investments that are not investment grade at the time of acquisition and that are not:

- a. Securities rated 5 or higher by the Securities Valuation Office of the National Association of Insurance Commissioners at the time of acquisition;
- b. Asset-backed or mortgage-backed securities rated 3 or higher by the Securities Valuation Office of the National Association of Insurance Commissioners at the time of acquisition;
- c. Convertible bonds;
- d. Preferred or common stock; and
- e. Private equity or hedge funds.

99.11(2) *Securitization agreements.* The LPS securitization, the security-offering memorandum or other document issued to prospective investors regarding the offer and sale of a surplus note or other security shall include a disclosure that all or part of the proceeds of such insurance securitization will be used to fund the LPS's obligations to the ceding insurer.

99.11(3) *Admitted assets.* Admitted assets of the LPS shall include proceeds from a securitization, premium and other amounts payable by a ceding insurer to the LPS, letters of credit, guaranties of a parent, and any other assets approved by the commissioner, which shall be deemed to be, and reported as, admitted assets of the LPS. The commissioner has the authority to reduce the amount of admitted assets previously approved by the commissioner, other than assets already covered by the Accounting Practices and Procedures Manual of the National Association of Insurance Commissioners, if the commissioner determines that the value of those assets has decreased. At least 30 days prior to reducing the amount of admitted assets previously approved, the commissioner shall notify the LPS and provide the LPS an opportunity to remedy the issues identified by the commissioner.

99.11(4) *Loans.* An LPS shall not make a loan to or an investment in any person, other than as permitted in the LPS's plan of operation, without prior written approval of the commissioner, and any

such loan or investment must be evidenced by documentation approved by the commissioner. Loans of minimum capital and surplus funds are prohibited.

99.11(5) *Investments in LPS.* The organizing life insurance company shall report its ownership in the LPS and value such ownership equal to the audited statutory surplus of the LPS.

[ARC 9229B, IAB 11/17/10, effective 12/22/10]

191—99.12(508) *Securities.* An LPS security shall not be subject to regulation as an insurance or reinsurance contract. An investor in such a security or a holder of such a security shall not be considered to be transacting the business of insurance in this state solely by reason of having an interest in the security. The underwriter's placement or selling agents and their partners, commissioners, officers, members, managers, employees, agents, representatives, and advisors involved in an insurance securitization by an LPS shall not be considered to be insurance producers or brokers or to be conducting business as an insurance or reinsurance company or as an insurance agency, brokerage, intermediary, advisory, or consulting business solely by virtue of their underwriting activities in connection with such securitization.

[ARC 9229B, IAB 11/17/10, effective 12/22/10]

191—99.13(505,508) *Permitted reinsurance.*

99.13(1) An LPS may reinsure, pursuant to a reinsurance contract, only the risks of a ceding insurer.

99.13(2) Unless otherwise approved in advance by the commissioner, an LPS may not assume or retain exposure to reinsurance losses for its own account that are not funded by one or more of the following:

- a. Proceeds from a securitization.
- b. Premium and other amounts payable by the ceding insurer to the LPS pursuant to the reinsurance contract.
- c. Letters of credit.
- d. Guaranties of a parent.
- e. Any return on investment of the items in paragraph "a" or "b" of this subrule.

99.13(3) An LPS may cede risks assumed through a reinsurance contract to one or more reinsurers through the purchase of reinsurance, subject to the prior approval of the commissioner.

99.13(4) An LPS may enter into contracts and conduct other commercial activities related or incidental to and necessary to fulfill the purposes of a reinsurance contract, an insurance securitization, and this chapter, provided such contracts and activities are included in the LPS's plan of operation or are otherwise approved in advance by the commissioner. Such contracts and activities may include but are not limited to: entering into reinsurance contracts; issuing LPS securities; complying with the terms of these contracts or securities; entering into trust, guaranteed investment contract, swap, or other derivative, tax, administration, services reimbursement, or fiscal agent transactions; complying with trust indenture, reinsurance, or retrocession; or entering into other agreements necessary or incidental to effect a reinsurance contract or an insurance securitization in compliance with this chapter and the LPS's plan of operation.

99.13(5) Unless otherwise approved in advance by the commissioner, a reinsurance contract shall not contain any provision for payment by the LPS in discharge of its obligations under the reinsurance contract to any person other than the ceding insurer or any receiver of the ceding insurer.

[ARC 9229B, IAB 11/17/10, effective 12/22/10]

191—99.14(505,508) *Certification of actuarial officer.* At the time an LPS files an application for a certificate of authority pursuant to subrule 99.5(2) and thereafter by March 1 of each year that an LPS is in operation and is ceded new business from a ceding insurer, a senior actuarial officer of each ceding insurer shall file with the commissioner a certification that the ceding insurer's transactions with an LPS are not being used to gain an unfair advantage in the pricing of the ceding insurer's products. A ceding insurer shall not be deemed to have an unfair advantage if the pricing of the policies and contracts reinsured by the LPS reflects, at the time those policies and contracts were issued, a reasonable long-term estimate of the cost to the ceding insurer of an alternative third-party transaction and utilizes current pricing

assumptions. The ceding insurer shall keep documentation between examinations that sets forth how a senior actuarial officer arrived at the conclusions in the certification.

[ARC 9229B, IAB 11/17/10, effective 12/22/10]

191—99.15(505,508) Effective date. This chapter is applicable on or after December 22, 2010.

[ARC 9229B, IAB 11/17/10, effective 12/22/10]

These rules are intended to implement Iowa Code sections 505.8 and 508.33A.

[Filed ARC 9229B (Notice ARC 9080B, IAB 9/22/10), IAB 11/17/10, effective 12/22/10]

[Filed ARC 5515C (Notice ARC 5389C, IAB 1/13/21), IAB 3/10/21, effective 4/14/21]

REGULATED INDUSTRIES

CHAPTER 100

SALES OF CEMETERY MERCHANDISE, FUNERAL MERCHANDISE
AND FUNERAL SERVICES

[Prior to 11/25/15, see Chs 100 to 105]

191—100.1(523A) Purpose. This chapter is promulgated to implement and administer Iowa Code chapter 523A, which regulates the sale of cemetery merchandise, funeral merchandise, funeral services and any combination of those items.

[ARC 2258C, IAB 11/25/15, effective 12/30/15; ARC 2730C, IAB 9/28/16, effective 11/2/16]

191—100.2(523A) Definitions. The definitions in Iowa Code chapter 523A are incorporated by this reference. In addition, the following definitions shall apply to this chapter:

“*Active license*” means a license that is in effect and in good standing.

“*Commissioner*” means the Iowa insurance commissioner or staff of the Iowa insurance division as designated by the commissioner.

“*Commissioner’s website*” means the website of the Iowa insurance division, www.iid.iowa.gov.

“*Continuing education*” means planned, organized learning acts designed to maintain, improve, or expand a licensed person’s knowledge and to maintain and improve the safety and welfare of the public.

“*Credit*” means at least 50 minutes spent by a licensed person in actual attendance at and in completion of an approved continuing education activity.

“*Insurance*” means life insurance policies and annuity contracts, except where the context indicates otherwise.

“*License*” means an authorization to act issued by the commissioner, authorizing a person to act as preneed seller or a sales agent.

“*Licensed person*” means any person who holds a preneed seller or sales agent license pursuant to Iowa Code chapter 523A, including any person who holds an active or restricted license.

“*Merchandise or services*” means cemetery merchandise, funeral merchandise, funeral services, or a combination thereof, as defined in Iowa Code section 523A.102, unless the context clearly indicates otherwise.

“*Person*” means an individual; corporation; business trust; estate; trust; partnership; limited liability company; association; cooperative; joint venture; government; governmental subdivision, agency, or instrumentality; public corporation; or any other legal or commercial entity.

“*Purchase agreement*” means an agreement to furnish merchandise or services when performance or delivery may be more than 120 days following the initial payment on the account.

“*Restricted license*” means an active license that has been placed on restricted status by the commissioner.

“*Sales log*” means a record of each sale of a purchase agreement.

[ARC 2258C, IAB 11/25/15, effective 12/30/15; ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—100.3(523A) Contact and correspondence.

100.3(1) Contact information. All mailed complaints, inquiries and correspondence shall be sent to Securities and Regulated Industries Bureau, Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315. Telephone inquiries may be made at (877)955-1212. Electronic submissions and correspondence may be made through the commissioner’s website.

100.3(2) Complaints, inquiries and correspondence. The commissioner may receive and process any complaint made regarding merchandise or services, or regarding a sales agent or a preneed seller, that alleges certain acts or practices which may constitute one or more violations of the provisions of this chapter. Where appropriate, the commissioner may refer complaints, in whole or in part, to other agencies. Any member of the public or the industry, or any federal, state, or local official, may make and file a complaint with the commissioner. If required by the commissioner, complaints shall be made on forms prescribed by the commissioner.

100.3(3) Forms and instructions. Copies of all required forms and instructions are available on the commissioner's website.

[ARC 2258C, IAB 11/25/15, effective 12/30/15; Editorial change: IAC Supplement 9/23/20; ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—100.4 to 100.9 Reserved.

191—100.10(523A) License status. Preneed seller licenses and sales agent licenses have the following three statuses:

100.10(1) No license. A person has no current preneed seller or sales agent active or restricted license issued by the commissioner.

100.10(2) Active license. A person has had a license issued by the commissioner, it is current in renewals, and it is otherwise in good standing.

100.10(3) Restricted license. A person has had an active license issued by the commissioner, the license is current in renewals, but the active license has been placed on restricted status by the commissioner.

a. The commissioner may place a license in restricted status for various reasons including, but not limited to, the following:

- (1) Disciplinary action.
- (2) Failure to pay state debt or child support.
- (3) Nondisciplinary reason if requested by the person.
- (4) Cessation of business.

b. A person whose license is restricted shall not enter into purchase agreements or sell merchandise or services, but may perform administrative duties related to sales made before the license was placed on restricted status.

c. A person whose license is restricted and who wishes to maintain a restricted status license shall meet the requirements for license renewal in rule 191—100.15(523A) by the required date. If the restricted license is not renewed, the license shall lapse at the end of its term.

[ARC 2258C, IAB 11/25/15, effective 12/30/15; ARC 4848C, IAB 1/1/20, effective 2/5/20]

191—100.11(523A) Application for license. To obtain a preneed seller license as required by Iowa Code section 523A.501 or a sales agent license as required by Iowa Code section 523A.502, a person must submit an application to the commissioner pursuant to this rule. A person shall not accept any payment or funding, including the assignment of ownership of or proceeds from insurance, related to the purchase of merchandise or services in Iowa, if the sale of the merchandise or services is subject to Iowa Code chapter 523A, unless the person holds an active license. Application forms and instructions may be obtained from the commissioner's website.

100.11(1) Preneed seller application. A person that desires to be licensed as a preneed seller must submit all of the following:

a. A completed application form.

b. A signed waiver and the required fee allowing the commissioner to request and obtain, pursuant to Iowa Code section 523A.501, criminal history data information for each owner and director of the applicant, including, but not limited to, for each sole proprietor, partner, director, officer, managing partner, member, shareholder with 10 percent or more of the stock, or other person with a financial interest in the preneed seller, who has the ability to control or direct control of trust funds under Iowa Code chapter 523A, as determined by the commissioner.

c. A financial history, if requested by the commissioner, for each owner and director of the applicant, including, but not limited to, for each sole proprietor, partner, director, officer, managing partner, member, or shareholder with 10 percent or more of the stock.

d. Evidence of a fidelity bond or insurance or a statement that demonstrates compliance with Iowa Code section 523A.201.

e. Payment of the appropriate license fee.

100.11(2) Sales agent application. An individual who desires to be licensed as a sales agent must satisfy the following requirements:

- a. Be at least 18 years of age.
 - b. Submit a completed application form.
 - c. Submit a signed waiver and the required fee allowing the commissioner to request and obtain criminal history data information, pursuant to Iowa Code section 523A.501.
 - d. Pay the appropriate license fee.
- [ARC 2258C, IAB 11/25/15, effective 12/30/15; ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—100.12(523A) Processing of application for a license.

100.12(1) Information to be reviewed for evaluation of application for a license. In order to determine whether to approve or deny an application for a license, the commissioner shall review all information that is submitted with the application, obtained through criminal history investigation pursuant to Iowa Code sections 523A.501(3) and 523A.502(4), and submitted pursuant to a commissioner's request.

a. The commissioner may require any documents reasonably necessary to verify the information contained in the application or to verify that the individual making application has the character and competency required to receive a license. The commissioner also may request fingerprints and reimbursement of costs for investigating a criminal history, pursuant to Iowa Code sections 523A.501(3) and 523A.502(4).

b. The commissioner shall conduct the criminal history data request and other investigations pursuant to Iowa Code sections 523A.501(3) and 523A.502(4). For purposes of preneed sellers' licenses, pursuant to Iowa Code section 523A.501(3), the commissioner's investigation of criminal history data and financial history shall be limited to persons who have the ability to control or to direct the control of trust funds under Iowa Code chapter 523A, as determined by the commissioner. The commissioner may deny the application for a license based on an applicant's conviction in any jurisdiction for a criminal offense involving dishonesty or a false statement.

100.12(2) Incomplete application. If the application form is not completed according to the instructions, or if all of the information in the instructions or requested by the commissioner is not provided, the commissioner shall reject the application and send a notice to the applicant identifying the problems with the license application and listing any corrective action necessary before the resubmission of an application.

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.13(523A) Approval and denial of license applications; issuance of license.

100.13(1) Approval of license application. If the commissioner approves a license application, the commissioner shall issue a license, the term of which shall begin the day the license is issued and end April 15.

100.13(2) License denial. The commissioner may deny a license application based on information received during the application process, on any ground listed in Iowa Code section 523A.503 or rules 191—100.16(523A) and 191—100.40(523A).

a. *Notice of denial.* When the commissioner denies an application for a preneed seller or sales agent license, the commissioner shall send a denial letter to the applicant by certified mail, return receipt requested, or in the manner of service of an original notice. The denial letter shall serve as notice of the denial and shall explain why the commissioner denied the application.

b. *Appeal.* An applicant that desires to contest the denial of an application may request a contested case proceeding pursuant to 191—Chapter 3 within 30 calendar days of the date the notice of denial is mailed. A failure to timely request a hearing constitutes failure to exhaust administrative remedies. License denial hearings under this chapter shall be conducted pursuant to 191—Chapter 3. License denial hearings and all documents related thereto are contested cases open to the public pursuant to Iowa Code chapters 17A and 22. While each party shall have the burden of establishing the matters asserted, the applicant shall have the ultimate burden of persuasion as to the applicant's qualification for licensure.

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.14(523A) Continuing education requirements. For each license term, each licensed sales agent shall complete a minimum of three credits of continuing education in courses acceptable to the commissioner, which may include independent study courses, pursuant to paragraph 100.14(2)“g.” Completion of the required continuing education is mandatory for the renewal of a sales agent license. “Independent study” means a subject, program or activity that a person pursues autonomously that meets the requirements of this rule and that includes a test at the conclusion of the independent study. Independent study includes but is not limited to programs conducted using television, the Internet, video, sound-recorded programs, correspondence work, and other similar media.

100.14(1) Exemption. The requirements of this rule do not apply to:

- a. A licensed funeral director.
- b. A licensed insurance producer.
- c. A licensed sales agent who served full time in the U.S. armed forces on active duty during a substantial part of the continuing education term and who submits evidence of such service.

100.14(2) General rules for continuing education credits.

a. The topic of at least one of the three continuing education credits earned each license term must be business ethics.

b. Proof of completion of a continuing education course shall, at a minimum, include all of the following, in a format acceptable to the commissioner:

(1) The date of the course, the location of the course, the course title, the course subject, and the identity and qualifications of the presenters.

(2) The number of course credits.

(3) Proof of successful completion of the course provided by the person conducting or sponsoring the course.

c. A sales agent cannot receive continuing education credit for courses taken prior to the issuance of an initial license.

d. A sales agent cannot receive continuing education credit for the same course twice in one license term.

e. A sales agent cannot carry over to the next license term more than three continuing education credits earned in excess of the sales agent’s license term requirements.

f. An instructor of a course is entitled to the same credit as a student completing that course; the instructor may receive such credit once during a license term, regardless of how many times the instructor teaches the class.

g. A sales agent may receive continuing education credit for independent study courses that are part of a recognized national designation program. A sales agent may receive up to three continuing education credits for independent study courses during a license term. A sales agent shall maintain a record from the course provider that the course was completed and the examination was passed.

100.14(3) Maintenance of records of completion of continuing education requirements. A sales agent shall maintain for three years after the license term during which the course was taken the original proof of completion and descriptions and outlines of all completed continuing education courses.

100.14(4) Standards for acceptable continuing education courses. The commissioner shall find a continuing education course acceptable if it meets all of the following criteria:

a. The course constitutes an organized program of learning which contributes directly to the professional competency of the licensee.

b. The course is conducted by individuals who have specialized training concerning the subject matter of the course.

c. The person conducting or sponsoring the course provides proof of attendance to attendees.

d. The activity pertains to subject matters which integrally relate to the sale of merchandise or services and purchase agreements subject to Iowa Code chapter 523A.

(1) The following are examples of acceptable course topics:

1. Ethics.

2. Mortuary science law; public health; and technical standards, requirements and issues regarding the handling and interment of deceased human remains.

3. Insurance.
 4. Iowa laws and administrative rules related to Iowa Code chapters 523A and 523I.
 5. Technical information related to merchandise or services used in the death care industry.
 6. Medicaid and the Iowa estate recovery law, Iowa Code section 249.53.
 7. Relevant federal laws and regulations such as the Federal Trade Commission Funeral rule (16 CFR Part 453).
 8. Information provided in programs or courses offered or sponsored by a state or national funeral association that otherwise meets the criteria in this subrule.
- (2) The following are examples of course topics that are not acceptable for continuing education credit:
1. Sales.
 2. Motivation.
 3. Purchaser prospecting.
 4. Supportive office skills (e.g., typing, filing, computer systems).
 5. Other subjects not specifically related to the death care industry.
- [ARC 2258C, IAB 11/25/15, effective 12/30/15; ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—100.15(523A) License renewal.

100.15(1) Procedure for renewal. The commissioner shall renew preneed sellers' licenses, pursuant to Iowa Code section 523A.501(7), or sales agents' licenses, pursuant to Iowa Code section 523A.502(5), for both active and restricted status licenses, if the preneed sellers or sales agents provide to the commissioner all of the following, which must be received by the commissioner on or before April 15 of each year:

a. Annual report. A preneed seller or sales agent shall file a complete and accurate annual report in the form and manner directed by the commissioner. A preneed seller's report must include information on affiliated sales agents as provided in the instructions. The form and instructions may be obtained through the commissioner's website.

b. Verification of completion of continuing education. A sales agent shall have completed the continuing education required by rule 191—100.14(523A) and shall attest to completion of the continuing education and compliance with all instructions on the commissioner's website.

c. Renewal fee. A preneed seller or sales agent shall submit a renewal fee as set out in rule 191—100.18(523A). Failure to include the proper amount shall be cause for the renewal to be rejected.

100.15(2) Renewal of a restricted license. A preneed seller or sales agent whose license is in restricted status and who seeks to continue to conduct actions administering purchase agreements created before the license is placed in restricted status must comply with the renewal process of this rule.

100.15(3) Lapse of license. If one of the items required by subrule 100.15(1) is not provided by April 15 of each year or is incomplete or if no application for renewal is received, the preneed seller or sales agent license shall lapse. The commissioner shall notify the preneed seller or sales agent of the reason for the lapse.

100.15(4) Commissioner's option not to permit renewal. The commissioner may choose not to renew a license for any of the reasons listed in Iowa Code section 523A.503 or rules 191—100.16(523A) and 191—100.40(523A).

[ARC 2258C, IAB 11/25/15, effective 12/30/15; ARC 2730C, IAB 9/28/16, effective 11/2/16; ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—100.16(523A) Prohibited activities related to licensing.

100.16(1) Fraudulent or deceptive acts in procuring a license. An individual shall not engage in fraudulent or deceptive acts in procuring a preneed seller or sales agent license. Prohibited acts include but are not limited to the following:

- a.* False representations of a material fact, whether by conduct or by false or misleading statements.
- b.* Concealing or omitting anything that should have been disclosed or included with the application.
- c.* Filing a false identification.

- d. Filing an untrue certification or affidavit.
- e. Falsifying documents.

100.16(2) Prohibited activities by persons without a preneed seller or sales agent license.

a. A person to whom a license has not been issued by the commissioner, or a person whose license has expired or is restricted, shall not conduct any of the activities for which an active license is required pursuant to Iowa Code chapter 523A or this chapter, including the following:

- (1) Post or display the person's license;
- (2) Use a license certificate or a license number, except in communications with the commissioner;
- (3) Agree to provide any merchandise or services subject to Iowa Code chapter 523A after the date the license expired or became restricted, unless the merchandise or services are provided pursuant to an existing purchase agreement.

b. This subrule does not prohibit payments to an unlicensed person upon the person's delivery of merchandise or services after the death of a beneficiary, including the payment of the proceeds of insurance at the time of death of the insured.

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.17(523A) Reinstatement of a restricted license.

100.17(1) Definition. The term "reinstatement" as used in this rule means changing the status of a license from restricted to active.

100.17(2) Application for reinstatement. Any preneed seller or sales agent whose license is restricted may request reinstatement by filing an application for reinstatement with the commissioner. Instructions can be found on the commissioner's website. If the licensed person meets all conditions of licensure, the commissioner shall reinstate the license.

100.17(3) Reinstatement after disciplinary action. If the restricted status of the license was the result of a disciplinary action, or was a forfeiture by the preneed seller or sales agent in connection with a disciplinary action, reinstatement must be in accordance with the terms of the applicable order or consent agreement. An application for reinstatement shall allege facts which, if established, will be sufficient to enable the commissioner to determine that the basis for placing the license in restricted status no longer exists. Before determining whether to grant reinstatement, the commissioner may review a financial history report for the time period during which the license was restricted.

100.17(4) Reinstatement after preneed seller's change of ownership or cessation of business operations. If the restricted status of a preneed seller's license was the result of the preneed seller's change of ownership or cessation of business operations under rule 191—100.35(523A), an application for reinstatement shall allege facts which, if established, will be sufficient to enable the commissioner to determine that the basis for placing the license in restricted status no longer exists. Before determining whether to grant reinstatement, the commissioner may review a financial history report for the time period during which the license was restricted.

100.17(5) Reinstatement after failure to pay child support. If the restricted status of the license was the result of a suspension for failure to pay child support pursuant to paragraph 100.40(2) "j," the application for reinstatement shall include proof from the Iowa child support recovery unit that the outstanding child support has been paid.

100.17(6) Reinstatement after failure to pay student loan debt. Rescinded IAB 1/1/20, effective 2/5/20.

100.17(7) Reinstatement after failure to pay state debt. If the restricted status of the license was the result of a suspension for failure to pay state debt pursuant to paragraph 100.40(2) "l," the application for reinstatement shall include proof from the centralized collection unit of the department of revenue that the outstanding state debt has been paid.

[ARC 2258C, IAB 11/25/15, effective 12/30/15; ARC 4848C, IAB 1/1/20, effective 2/5/20; ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—100.18(523A) Payment of fees.

100.18(1) Manner of payment. Fees shall be paid by electronic payment as permitted by the commissioner.

100.18(2) Nonrefundable. Fees are not refundable.

100.18(3) Specific fees. Fees are set by Iowa Code chapter 523A and by this chapter.

a. The license fee for a preneed seller applicant is \$25, plus \$15 for each criminal history request made on each individual for whom a criminal history is required by Iowa Code section 523A.501(3).

b. The license fee for a sales agent applicant is \$10, plus \$15 for each criminal history background check.

c. The fee for a license renewal is \$15 for a preneed seller and \$10 for a sales agent.
[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.19(523A) Master trusts.

100.19(1) Creation of master trusts. Pursuant to Iowa Code section 523A.203, a preneed seller may commingle the care funds of multiple beneficiaries in a master trust. When a preneed seller enters into a master trust agreement and establishes a master trust agreement at a financial institution:

a. The title of the financial account shall include the name of the preneed seller and be identified as a master trust account.

b. Rescinded IAB 3/10/21, effective 4/14/21.

c. Either the preneed seller or the financial institution shall maintain the detailed listing as required by Iowa Code section 523A.203(3) by keeping the following:

(1) One listing of the amount deposited in trust for each beneficiary; and

(2) A separate accounting of each purchaser's principal, interest, and income, and balance in trust for each beneficiary who has care funds in the master trust account.

100.19(2) Reporting of master trusts.

a. As part of the preneed seller's annual report required by paragraph 100.15(1) "a," a preneed seller shall submit all of the following:

(1) The aggregate amount of deposits made to the master trust account during the calendar year.

(2) The aggregate amount of withdrawals made from the master trust account during the calendar year.

(3) Information detailing the name of any beneficiary related to a deposit to or withdrawal from the master trust account with the amount deposited or withdrawn by the beneficiary. The report shall include aggregate amounts of deposits and withdrawals for each beneficiary.

(4) Transactions, as described in the division's instructions for the annual report, for the calendar year in which the transactions took place.

b. A financial institution shall submit a report annually that includes all of the following information relating to activities in the master trust:

(1) The aggregate amount of deposits made to the master trust account for each beneficiary during the calendar year.

(2) The aggregate amount of withdrawals made from the master trust account for each beneficiary during the calendar year.

(3) Transactions, as described in the division's instructions for the annual report, for the calendar year in which the transactions took place.

(4) A copy of the bank account statement for the master trust account.

[ARC 2730C, IAB 9/28/16, effective 11/2/16; ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—100.20(523A) Trust interest or income. A preneed seller may withdraw interest or income, as defined by Iowa Code section 523A.102, from trusts holding funds which are established pursuant to Iowa Code section 523A.201(8) and which are related to purchase agreements executed on or after July 1, 1987, in accordance with this rule.

100.20(1) Amount of trust interest or income which may be withdrawn. Trust interest and income must remain in trust and cannot be withdrawn by a preneed seller, except that a preneed seller may withdraw from a purchase agreement trust fund any interest and income credited to the trust during the preceding calendar year in excess of the sum of the following amounts, which sum must be retained in trust:

a. Fifty percent of the total interest and income credited to the trust during the preceding calendar year, and

b. An additional amount necessary to adjust the trust funds for inflation, as set by the commissioner based on the consumer price index pursuant to rule 191—100.22(523A).

100.20(2) *Allocation of trust interest or income to purchasers' accounts.* Interest and income not withdrawn from a purchase agreement trust fund shall be allocated pro rata to the purchase agreement accounts remaining in the trust at the end of the month in which the withdrawal was made.

100.20(3) *Credit for trust interest or income withdrawn.* The early withdrawal of interest or income under this rule does not affect the purchaser's right to a credit of such interest or income in the event of a nonguaranteed price agreement, cancellation of the purchase agreement, or nonperformance by the preneed seller.

100.20(4) *Time period during which trust interest or income may be withdrawn.* Interest or income withdrawals permitted by this rule shall be made up to 180 days after the calendar year in which the interest or income was earned.

100.20(5) *Application of contract law.* A purchase agreement may limit or prohibit a preneed seller's ability to withdraw income or interest. However, in the event of a conflict with the limitations set forth in this rule, the preneed seller must comply with the requirements of this rule.

[ARC 2258C, IAB 11/25/15, effective 12/30/15; ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—100.21(523A) Cancellation refunds. The requirement set forth in Iowa Code section 523A.602(2) "b"(1) applies to any purchase agreement executed on or after July 1, 2001.

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.22(523A) Consumer price index adjustment. The inflation factor adjustment to be used for Iowa Code sections 523A.201(8) and 523A.602(2) "b"(1), for years 1987 and later, shall be the consumer price index for all urban consumers (CPI-U) issued by the U.S. Department of Labor's Bureau of Labor Statistics.

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.23(523A) Preneed seller's use of surety bond in lieu of trust.

100.23(1) In lieu of the trust requirements of Iowa Code section 523A.405, a preneed seller may file with the commissioner a surety bond. The surety bond shall be in the form as directed by the commissioner and as available on the commissioner's website.

100.23(2) A surety bond claimant, for purposes of this rule, includes any purchaser whose purchase agreement predates the effective date of the surety bond or was executed during the surety bond's period of coverage and whose purchase agreement has not been rescinded, fulfilled, or secured by another bond, by other insurance, or by trust funds.

100.23(3) Except as provided in subrule 100.23(6), no suit or action shall be commenced by a surety bond claimant later than one year after the expiration date of the surety bond.

100.23(4) Any surety bond claimant as set forth in subrule 100.23(2) may maintain an action on the surety bond. A surety's aggregate liability shall not exceed the penal sum of the bond.

100.23(5) A surety shall not cancel a surety bond except upon written notice of cancellation given by the surety to the commissioner by certified mail. The effective date of the cancellation shall not be less than 60 days after the commissioner receives the surety's notice. The surety shall specify the reason for the cancellation.

100.23(6) The surety shall not be liable for any surety bond claim related to the preneed seller's insolvency or cessation of business unless the surety claim is made within five years of the date of insolvency or business cessation.

100.23(7) If the surety notifies the preneed seller that the surety intends to cancel a surety bond, the preneed seller, within 30 days, shall:

a. Submit to the commissioner a substitute surety bond complying with this rule; or

b. Deposit funds in an amount as required by Iowa Code chapter 523A to a trust account established by the preneed seller.

100.23(8) A preneed seller shall maintain an adequate surety bond and shall continuously monitor the surety amount to assure its adequacy. The surety bond amount shall be calculated based on the value of the purchase agreements sold and not performed or canceled and for which no trust fund or insurance is in place.

[ARC 2258C, IAB 11/25/15, effective 12/30/15; ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—100.24 Reserved.

191—100.25(523A) Funeral and cemetery merchandise warehoused by preneed sellers.

100.25(1) Applicability. This rule applies only to storage existing on or before July 1, 2007, under purchase agreements executed between July 1, 1987, and July 1, 2007.

100.25(2) Warehousing not permitted. After July 1, 2007, warehousing shall not be used as an alternative to the trust requirements of Iowa Code chapter 523A.

100.25(3) Approval of storage facilities by commissioner. Notwithstanding subrule 100.25(2), if a preneed seller receives approval in writing from the commissioner pursuant to subrule 100.25(4), the trust requirements of Iowa Code sections 523A.201 and 523A.202 do not apply to either:

- a. Payments for outer burial containers made of either polystyrene or polypropylene; or
- b. Cemetery merchandise delivered to the purchaser or stored in a storage facility not owned or controlled by the preneed seller.

100.25(4) Storage facility application. The commissioner shall approve a preneed seller's application to have a storage facility designated as an approved storage facility for purposes of subrule 100.25(3) if the following conditions are met:

a. *Insurance coverage and financial condition.* The storage facility shall demonstrate that adequate insurance against loss and damage has been purchased and that the storage facility's financial condition is commensurate with any financial obligations assumed. Proof of the storage facility's financial condition shall include submission of audited financial statements completed in accordance with generally accepted accounting principles, which shall include the following:

- (1) A balance sheet prepared as of a date within 120 days prior to the application; and
- (2) A profit and loss statement and any changes in financial position for each of the three fiscal years preceding the date of the balance sheet or, if the storage facility has been in existence less than three years, for the period of the storage facility's existence.

b. *Records system and maintenance.* The storage facility must demonstrate that it has a system that adequately records:

- (1) For each item in storage: an identification and a description; the ownership; name and address of the preneed seller; an order number; the order date; and the storage date.
- (2) An aggregate listing and numerical totals for the entire storage facility and for each state or province.

c. *Title, delivery, identification, payments.* The storage facility shall agree to comply with subrule 100.25(5).

d. *Storage requirements.* The storage facility shall provide storage that adequately provides both accessibility and protection against damage.

e. *Consent to audits and inspections.* The storage facility shall provide written consent to authorize audits, reviews and inspections by the commissioner pursuant to paragraph 100.25(5) "e" and written consent to provide reports requested pursuant to paragraph 100.25(5) "g."

f. *Compliance with law.* The storage facility shall be in compliance with all applicable laws regulating the applicant's activities as a warehouse keeper, manufacturer, supplier, or preneed seller of cemetery or funeral merchandise.

100.25(5) Storage facility duties.

a. *Title.* The storage facility shall provide to the preneed seller a minimum of two copies of a title certificate. The title certificate should not be issued until the merchandise is stored in substantially complete condition. Each preneed seller shall deliver at least one copy of the title certificate to the purchaser and shall retain one copy in the preneed seller's records.

b. Delivery requirements. The storage facility shall not accept prepayment of delivery expenses or charges. The storage facility shall provide written disclosure to the preneed seller that delivery costs will be billed at the time of delivery. The storage facility shall require the purchaser's signature, or the signature of the purchaser's legal representative, prior to the delivery of the cemetery or funeral merchandise.

c. Storage requirements. The storage facility shall adequately provide accessibility to the stored merchandise and adequately protect the stored merchandise against damage.

d. Identification of merchandise. The storage facility shall allow for visual inspection and counting; have storage by type or style; identify the location of the item by a shelf and bin- or slot-type system or reasonable alternative; and keep totals for each type of merchandise item in storage.

e. Audits and examinations. The storage facility shall allow the commissioner to examine the books, papers, records, memoranda or other documents of the storage facility and stored merchandise for the purpose of verifying compliance with Iowa Code chapter 523A and this rule. Unless waived by the commissioner in writing, the transportation, meal and lodging expenses of the auditors and examiners shall be reimbursed by the storage facility.

f. Identification of merchandise. All cemetery merchandise must be appropriately marked, identified and described in a manner to distinguish it from other similar items of merchandise, unless the commissioner has given to the seller prior written waiver of this requirement upon a showing of good cause.

g. Reports. The commissioner may request reports containing information about the storage facility, including but not limited to the following:

(1) A description of the storage facility, including the name, address of the principal business office, state or province of organization, date of organization, type of entity (e.g., corporation or partnership), and location of all storage facilities;

(2) A description of the storage program; and

(3) A detailed description of all merchandise currently in storage, which shall include all of the following:

1. The date the merchandise was first placed in storage;

2. The full name of the purchaser or the person on whose behalf the merchandise was purchased;

3. The location of the merchandise, which shall include the location within the facility utilizing a numbering system that provides the exact location of each item;

4. The name and address of the preneed seller;

5. The total number of items, by category, in storage at the facility for preneed sellers located in this state; and

6. The total number of items, by category, in storage at the facility.

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.26 to 100.29 Reserved.

191—100.30(523A) Standards of conduct for preneed sellers and sales agents. Rules 191—100.30(523A) through 191—100.36(523A) are intended to establish certain minimum standards and guidelines of conduct for preneed sellers and sales agents by identifying required actions or practices. Failure to comply with these rules may be grounds for action under Iowa Code chapter 523A or rule 191—100.40(523A) or 191—100.41(523A).

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.31(523A) Advertisements, sales practices and disclosures.

100.31(1) Advertising.

a. A preneed seller or sales agent shall not engage in any act or practice that violates Iowa Code section 523A.702 or 523A.703, whether or not actual harm or injury occurs, including but not limited to making untrue or improbable statements in advertisements.

b. An advertisement for the solicitation or sale of a purchase agreement which is to be funded by insurance shall adequately disclose the following:

- (1) The fact that insurance is to be involved or used to fund a purchase agreement, and
- (2) The nature of the relationship among the sales agent, the preneed seller, the provider of merchandise or services, and any other person.

100.31(2) *Unethical, harmful or detrimental sales practices.* A preneed seller or sales agent shall not engage in any act or practice which may be harmful or detrimental to the public, whether or not actual harm or injury occurs, while engaged in activities regulated by Iowa Code chapter 523A, or materially related to such activity, including but not limited to:

- a. Encouraging cancellation of a purchase agreement if cancellation is not in the best interests of the purchaser.
- b. Encouraging a change in the funding method of a purchase agreement, including a change from one insurance company to another, if the change is not in the best interest of the purchaser.
- c. Failure to leave a residence when requested to do so.
- d. Intimidation or physical abuse, including improper sexual contact or conduct.
- e. Any other act or practice that takes unfair or unreasonable advantage of the vulnerability of a purchaser or prospective purchaser based on age, poor health, infirmity, impaired understanding, restricted mobility, or disability.

100.31(3) *Disclosures.*

- a. Reserved.
- b. Prior to accepting an application, initial premium, or deposit for insurance which is to fund a purchase agreement, a preneed seller or sales agent must adequately disclose to the potential purchaser in writing all of the following:

- (1) The relationship of the insurance to the funding of the purchase agreement and the nature and existence of any guarantees relating to the purchase agreement.

- (2) The impact on the purchase agreement of any of the following:

1. Changes in the insurance 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 insurance.

- (3) All merchandise or services to be supplied pursuant to the contract or purchase agreement 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.

- (4) All relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the proceeds of the insurance and the amount actually needed to fund the purchase agreement.

- (5) Any penalties including, but not limited to, penalties for the inability of the preneed seller to deliver merchandise or services or to fulfill the purchase agreement guarantee.

- (6) Any restrictions including, but not limited to, geographic restrictions.

- (7) Whether any sales commission or other form of compensation is being paid related to the insurance and the identity of the individual or entity to which the compensation is to be paid. It is not necessary that the amount be disclosed.

- c. Reserved.

- d. Regardless of the type of funding for the purchase agreement, at the time of providing a written itemized cost estimate for the purchase of preneed merchandise or services:

- (1) The sales agent shall provide to the potential purchaser a copy of the Iowa insurance division's Guide to Prearranged Funeral Plans, or a document in similar format and with substantially similar language.

- (2) The sales agent shall include on the cost estimate clear statements indicating:

1. The date after which the estimate or proposal expires.
2. That prices are subject to change after the cost proposal expires.
3. That the prices provided are a nonbinding estimate and do not create a binding contract or agreement with the preneed seller.

(3) The sales agent shall provide a copy of the cost estimate to the potential purchaser and shall retain a copy of the cost estimate in the preneed seller's records for at least five years.

For purposes of this rule, a price list is not a cost estimate.

e. Regardless of the type of funding for the purchase agreement, a purchase agreement that describes the purchase price as "guaranteed" shall disclose the nature and details of the guarantee. For items described as "guaranteed," the purchaser, beneficiary and the beneficiary's estate shall not be obligated to pay additional costs if costs at the time merchandise or services are delivered or provided are greater than the funds available from the allocable portion of payments and accumulated income or growth, as long as the funding is not limited in any manner, such as by the failure to make contractual or premium payments.

f. If a purchase agreement is to be funded by a trust, the purchase agreement shall disclose that 100 percent of all payments related to merchandise or services described in the purchase agreement as "nonguaranteed" shall be placed in trust in accordance with Iowa Code section 523A.201(2).

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.32 Reserved.

191—100.33(523A) Records maintenance and retention.

100.33(1) *By preneed sellers.*

a. Time for retaining records. If no other legal provision governs record retention, a preneed seller shall keep all records required to be kept by this rule either from the date of the preneed seller's last examination by the commissioner or for a minimum of five years after the date of the death of the beneficiary, whichever is sooner.

b. Confidentiality. The preneed seller shall keep social security numbers confidential.

c. Sales log and numbering of purchase agreements. A preneed seller shall maintain a sales log of purchase agreements, assigning numbers in sequential order to each purchase agreement sold during a calendar year.

(1) Prenumbered contracts are not required. If a contract is not prenumbered, the sales agent shall write the contract number on the purchase agreement at the time it is executed or in a document provided later to the purchaser.

(2) The copy of the purchase agreement given to the purchaser shall include the contract number assigned to the purchase agreement.

(3) If a correction to the contract number is required, the correction shall be recorded in the sales logs, and documentation that retains evidence of the initial number used shall be maintained.

(4) Preneed sellers shall use the following numbering system, unless they receive written permission from the commissioner to use a different system.

1. The first portion of the number shall be the year the contract was written.

2. The second portion of the number shall be sequential and indicate the number of contracts executed by the preneed seller, to date, in the applicable calendar year.

3. Additional suffixes may be used as follows:

- A preneed seller with multiple locations may use a suffix to identify each location by number.
- A preneed seller with multiple sales agents may use a numerical suffix to identify the sales agent.

agent.

4. Each part of the number shall be separated by a hyphen.

An example of the numbering system is provided on the commissioner's website.

d. Transaction records. A preneed seller shall document all transactions with purchasers and prospective purchasers and maintain accurate copies and records of all purchase agreements.

e. Deposit records. Preneed sellers shall maintain records of all deposits made into accounts related to purchase agreements. If purchase agreement payments made to a preneed seller and funds not related to a purchase agreement are commingled and deposited together in a single account, or if a deposit to an account involves purchase agreement payments related to more than one purchase

agreement, the preneed seller shall retain a detailed summary of each deposit showing the amounts related to the different purchase agreements.

f. Record of sales agents. A preneed seller shall maintain a list of all sales agents who sold purchase agreements on behalf of the preneed seller during each calendar year. The records shall include the license number of each sales agent and the dates of the sales agent's employment. Upon the commissioner's request, these records shall be provided to the commissioner.

100.33(2) By sales agents. A sales agent shall maintain a sales log for a minimum of five years after the sale. The sales log shall include all of the information required for the sales agent's annual report. Instructions and an example are available on the commissioner's website.

[ARC 2258C, IAB 11/25/15, effective 12/30/15; ARC 2730C, IAB 9/28/16, effective 11/2/16; ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—100.34(523A) Changes in funding methods for or terms of purchase agreements. When a preneed seller or sales agent changes the funding method for a prepaid purchase agreement, this rule applies.

100.34(1) Change in funding of a purchase agreement. When a purchaser changes the funding source for a purchase agreement from a bank account or trust account to funding through insurance, or from insurance funding from one insurance company to another:

a. This type of change is deemed to be an amendment to the purchase agreement, not a cancellation of the original purchase agreement.

b. The amendment to the purchase agreement may include other minor updates to the statement of goods and services.

c. The preneed seller shall do all of the following:

(1) Obtain a written, signed and dated statement from the purchaser requesting the change in funding and acknowledging the transaction in a way that demonstrates the purchaser understood the change in funding transaction. A copy of the signed statement shall be provided to the purchaser, and a copy shall be retained by the preneed seller.

(2) Describe the change in funding in a written amendment to the purchase agreement. The amendment shall be signed and dated by the purchaser and the preneed seller. A copy of the signed amendment shall be provided to the purchaser, and a copy shall be retained by the preneed seller.

(3) If the funding change is from a bank account to an insurance account, record the amendment on the preneed seller's annual report as a reduction in cash accounts and an increase in insurance accounts.

(4) If the funding change is from a trust account to an insurance account:

1. Confirm that the policy shall have an increasing benefit, as specified in Iowa Code section 523A.401(5).

2. Record the amendment on the preneed seller's annual report as both a withdrawal from trust and an addition of insurance. Instructions are available on the commissioner's website.

3. Comply with record-keeping and reporting requirements for the sale of new insurance in Iowa Code sections 523A.401 and 523A.402.

(5) If the change in funding is from one insurance company to another:

1. Document compliance with the disclosure requirements of rule 191—15.8(523A).

2. Comply with the replacement requirements of rule 191—16.24(507B).

3. Record the amendment on the preneed seller's annual report as a change in funding from one insurance company to another. Instructions are available on the commissioner's website.

(6) For record maintenance purposes, use the number for the original purchase agreement, not a new assigned number.

100.34(2) Cancellation of a purchase agreement. When a purchaser makes substantive changes to a purchase agreement:

a. This type of change is deemed to be a cancellation of the existing purchase agreement and requires the preneed seller to execute a new purchase agreement.

b. The preneed seller shall do all of the following:

(1) Obtain a written signed and dated statement from the purchaser which cancels the existing purchase agreement. A copy of the signed statement shall be provided to the purchaser, and a copy shall be retained by the preneed seller.

(2) Obtain a written signed and dated statement from the purchaser which demonstrates that the purchaser understood the change from one purchase agreement to the other. A copy of the signed statement shall be provided to the purchaser, and a copy shall be retained by the preneed seller.

(3) Comply with the rescission requirements of Iowa Code section 523A.602.

(4) For record maintenance purposes, assign a new number for the new purchase agreement.

(5) Record the cancellation of the initial purchase agreement on its annual report.

[ARC 2258C, IAB 11/25/15, effective 12/30/15; ARC 5515C, IAB 3/10/21, effective 4/14/21]

191—100.35(523A) Preneed seller's change of ownership and cessation of business operations.

100.35(1) *Sale or transfer of purchase agreements or of business.* A preneed seller shall not change ownership of a business, sell all or part of a business, cease business, or sell or transfer purchase agreements as part of the sale of a business or the assets of a business, unless:

a. The preneed seller has notified the commissioner of the change at least 90 days prior to the sale or transfer.

b. The person receiving assets and purchase agreements has an active preneed seller's license at the time of the sale or transfer.

c. A certified public accountant has performed and filed with the commissioner an agreed-upon procedures (AUP) report or other audit acceptable to the commissioner, as required by Iowa Code section 523A.207.

d. The commissioner has conducted an examination of the sales and market practices of the preneed seller, if the commissioner requests.

e. The preneed seller has provided the commissioner with any other information required for the commissioner to approve the sale or transfer.

100.35(2) *Cessation of business by a preneed seller.* At least 90 days prior to the cessation of business operations, if a preneed seller voluntarily or involuntarily ceases doing business, and the preneed seller's obligation to provide merchandise or services has not been assumed by another preneed seller holding an active preneed seller's license, the preneed seller shall:

a. Send a notice to the commissioner, in a manner as directed by the commissioner. Pursuant to subrule 100.10(3), the commissioner shall place the preneed seller's license on restricted status when the preneed seller ceases doing business.

b. Send written notice of the proposed cessation of business to the purchaser and beneficiary, if different than the purchaser, of each purchase agreement by certified mail, return receipt requested. The notice shall indicate the preneed seller's ability to transfer any trust funds and transfer the proceeds from any insurance to another licensed preneed seller.

c. During the 90 days prior to the cessation of business operations, the preneed seller shall work with financial institutions and insurance companies to modify the title to financial accounts and modify assignments and ownership of annuities and insurance policies as necessary or distribute trust funds to the purchaser or transfer to another licensed preneed seller.

100.35(3) *Failure to notify the commissioner of a change of ownership, sale of a business, or cessation of business.*

a. A preneed seller's failure to notify the commissioner, as set forth in this rule, of a change of ownership of a business, sale of all or part of a business, cessation of business, or sale or transfer of purchase agreements as part of the sale of a business or the assets of a business may be a ground for penalty under rule 191—100.40(523A) or 191—100.41(523A).

b. If trust funds are transferred without compliance with this rule or with Iowa Code sections 523A.207 and 523A.602, the commissioner may petition for the appointment of a receiver pursuant to Iowa Code section 523A.811.

100.35(4) Annual reports. A preneed seller holding a restricted license shall continue to file annual reports pursuant to Iowa Code section 523A.204 regarding any purchase agreement not transferred to another seller holding a current preneed seller's license through an assumption agreement or otherwise.

For purposes of this rule, the sale of a business shall include any change of controlling interest in any corporation or other business entity.

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.36 to 100.39 Reserved.

191—100.40(523A) Prohibited practices for preneed sellers and sales agents.

100.40(1) The commissioner may impose sanctions as set forth in Iowa Code section 523A.807 and rules 191—100.40(523A) and 191—100.41(523A), or place a license in restricted status, if the commissioner finds that a preneed seller, sales agent, or owner, partner, member, director, shareholder or manager of a licensed business entity has violated or failed to comply with Iowa Code chapter 523A, this chapter, or any associated rules or implementing orders, or is otherwise unable to conduct activities as a preneed seller or sales agent.

100.40(2) Grounds for discipline include but are not limited to the following acts or practices:

a. *Fraudulent or deceptive practices.* Engaging in any act or practice that violates Iowa Code section 523A.701, 523A.702 or 523A.703, whether or not actual harm or injury occurs, including but not limited to:

- (1) Falsifying business records; or
- (2) Misappropriating funds.

b. *Responsibility for sales activities of others.* A preneed seller's consent or acquiescence to violation of this chapter or Iowa Code chapter 523A by any person acting on the preneed seller's behalf.

c. *Law violations.*

(1) Violating any state or federal law applicable to the conduct of the applicant's or licensee's business including, but not limited to, the following:

1. The provisions of Iowa Code chapter 156 pertaining to the licensure of funeral directors in the state of Iowa;
2. Regulations promulgated by the Federal Trade Commission relating to merchandise or services, or funeral or cremation establishments;
3. Applicable tax or public health laws, ordinances or regulations; or
4. Laws, rules, ordinances, or regulations occurring outside of Iowa if the commissioner determines that such violation may adversely implicate the licensee's or applicant's compliance with Iowa laws, rules, orders, ordinances, or regulations.

(2) Conviction of a criminal offense, in any jurisdiction, involving dishonesty or a false statement, including but not limited to fraud, theft, misappropriation of funds, falsification of documents, deceptive acts or practices, or other related offenses. "Conviction" shall include a plea of guilty or a finding of guilt and shall include a deferred judgment.

d. *Sales prohibited by order.* The sale of merchandise or services by a preneed seller or sales agent who has been prohibited from selling services or merchandise in an order issued pursuant to Iowa Code section 523A.807(3).

e. *Returned checks or declined credit transactions.* Submitting to the commissioner an electronic payment which is returned to the commissioner by a bank without payment, or submitting a payment to the commissioner by credit card which the credit card company does not approve, or canceling or refusing amounts charged to a credit card by the commissioner.

f. *Failure to maintain records.* Failure to maintain records as required by Iowa Code chapter 523A or any associated rules or orders.

g. Failure to cooperate with an examination or investigation. Failure to submit to an examination, failure to comply with a reasonable written request of an examiner, or failure to cooperate with an investigation conducted by the commissioner as required by Iowa Code sections 523A.206, 523A.803, 523A.808 and 523A.811 and any associated rules or orders.

h. Insolvency or unsound financial condition. Being or becoming insolvent or of unsound financial condition, the determination of which shall be based on but not limited to the following factors:

- (1) The licensee's or license applicant's net worth;
- (2) Whether a financial institution has closed or otherwise taken adverse action against an account held by or on behalf of the licensee or license applicant;
- (3) The licensee or license applicant has exhibited a pattern of writing bad checks or otherwise overdrawing a business or trust account as a result of insufficient funds;
- (4) Untimely payment by the licensee or license applicant of business obligations in a manner that threatens the operation of the business;
- (5) Untimely placement by the licensee of consumer funds into trust;
- (6) Failure of the licensee or license applicant to pay sales tax, unemployment tax or other tax owed in the course of business; or
- (7) Any other act, practice or omission that provides a reasonable basis to question the ability of the licensee or license applicant to comply with the requirements of Iowa Code chapter 523A and related regulations.

i. Inability to perform.

(1) Inability to provide the merchandise or services which the licensee purports to sell, including but not limited to failing to employ or have a contractual arrangement with at least one person who is licensed to perform mortuary science services, as described in Iowa Code chapter 156, if such services are included in a purchase agreement.

(2) Inability to reasonably provide merchandise or services due to an impairment, drug or alcohol addiction, or other act, conduct or condition. A licensee who has had a physical or mental impairment or illness during the license period may request to be placed on restricted status by the commissioner. Any such request shall be submitted on a form as specified by the commissioner and must include a signed statement of a licensed health care professional which attests to the existence of a disability or illness during the license period.

j. Suspension for failure to pay child support.

(1) Upon receipt of a certificate of noncompliance from the child support recovery unit (CSRU), the commissioner shall issue a notice to the sales agent that the sales agent's pending application for licensure, pending request for renewal, or current license will be suspended 30 days after the date of the notice. Notice shall be sent by regular mail to the sales agent's last-known address.

(2) The notice shall contain the following items:

1. A statement that the commissioner intends to suspend the sales agent's application, request for renewal or current license in 30 days;
2. A statement that the sales agent must contact the CSRU to request a withdrawal of the certificate of noncompliance;
3. A statement that the sales agent's application, request for renewal or current license will be suspended if the certificate of noncompliance is not withdrawn;
4. A statement that the sales agent does not have a right to a hearing before the commissioner, but that the sales agent may file an application for a hearing in district court pursuant to Iowa Code section 252J.9;
5. A statement that the filing of an application with the district court will stay the proceedings of the commissioner; and
6. A copy of the certificate of noncompliance.

(3) The filing of an application for hearing with the district court will stay all suspension proceedings until the commissioner is notified by the district court of the resolution of the application.

(4) If the commissioner does not receive a withdrawal of the certificate of noncompliance from the CSRU or a notice from a clerk of court that an application for hearing has been filed, the commissioner

shall suspend the sales agent's application, request for renewal or current license 30 days after the notice is issued.

(5) Upon receipt of a withdrawal of the certificate of noncompliance from the CSRU, suspension proceedings shall halt, and the named sales agent shall be notified that the proceedings have been halted. If the sales agent's license has already been suspended, the license shall be reinstated if the sales agent is otherwise in compliance with rules issued by the commissioner. All fees required for license renewal or license reinstatement must be paid by sales agents, and all continuing education requirements must be met before a sales agent license will be renewed or reinstated after a license suspension or revocation pursuant to this paragraph.

k. Suspension for failure to pay student loan. Rescinded IAB 1/1/20, effective 2/5/20.

l. Suspension for failure to pay state debt.

(1) The commissioner shall deny the issuance or renewal of a sales agent license upon receipt of a certificate of noncompliance from the centralized collection unit of the department of revenue according to the procedures in Iowa Code chapter 272D. In addition to the procedures set forth in Iowa Code chapter 272D, this subrule shall apply.

(2) Upon receipt of a certificate of noncompliance from the centralized collection unit of the department of revenue according to the procedures set forth in Iowa Code chapter 272D, the commissioner shall issue a notice to the sales agent that the sales agent's pending application for licensure, pending request for renewal, or current sales agent license will be suspended 60 days after the date of the notice. Notice shall be sent to the sales agent's last-known address by restricted certified mail, return receipt requested, or by personal service in accordance with the Iowa Rules of Civil Procedure. Alternatively, the applicant or licensed sales agent may accept service personally or through authorized counsel.

(3) The notice shall contain the following items:

1. A statement that the commissioner intends to suspend the sales agent's application, request for renewal or current sales agent license in 60 days;

2. A statement that the sales agent must contact the centralized collection unit of the department of revenue to schedule a conference or to otherwise obtain a withdrawal of the certificate of noncompliance;

3. A statement that the sales agent's application, request for renewal or current sales agent license will be denied or suspended if the commissioner does not receive a withdrawal of the certificate of noncompliance from the centralized collection unit of the department of revenue within 60 days of the issuance of notice under this rule; or, if the current sales agent license is on suspension, a statement that the sales agent's current sales agent license will be revoked;

4. A statement that the sales agent does not have a right to a hearing before the commissioner, but that the sales agent may file an application for a hearing in district court pursuant to Iowa Code section 272D.9;

5. A statement that the filing of an application with the district court will stay the proceedings of the commissioner; and

6. A copy of the certificate of noncompliance.

(4) Sales agents shall keep the commissioner informed of all court actions and all actions taken by the centralized collection unit of the department of revenue, and sales agents shall provide to the commissioner, within seven days of filing or issuance, copies of all applications filed with the district court pursuant to all court orders entered in such actions and copies of all withdrawals of certificates of noncompliance by the centralized collection unit of the department of revenue.

(5) The effective date of revocation or suspension of a sales agent license shall be 60 days following service of the notice upon the applicant or sales agent.

(6) In the event an applicant or licensed sales agent timely files a district court action following service of a notice by the commissioner, the commissioner's suspension proceedings will be stayed until the commissioner is notified by the district court of the resolution of the application. Upon receipt of a court order lifting the stay, or otherwise directing the commissioner to proceed, the commissioner shall continue with the intended action described in the notice. For purposes of determining the effective date

of the denial of the issuance or renewal of a sales agent license, the commissioner shall count the number of days before the action was filed and the number of days after the court disposed of the action.

(7) If the commissioner does not receive a withdrawal of the certificate of noncompliance from the centralized collection unit of the department of revenue or a notice from a clerk of court that an application for hearing has been filed, the commissioner shall suspend the sales agent's application, request for renewal or current sales agent license 60 days after the notice is issued.

(8) Upon receipt of a withdrawal of the certificate of noncompliance from the centralized collection unit of the department of revenue, suspension proceedings shall halt, and the named sales agent shall be notified that the proceedings have been halted. If the sales agent's license has already been suspended, the license shall be reinstated if the sales agent is otherwise in compliance with this chapter. All fees required for license renewal or license reinstatement must be paid by the sales agent, and all continuing education requirements must be met before a sales agent license will be renewed or reinstated after a license suspension or revocation pursuant to Iowa Code chapter 272D.

(9) The commissioner shall notify the sales agent in writing through regular first-class mail, or such other means as the commissioner deems appropriate in the circumstances, within ten days of the effective date of the suspension or revocation of a sales agent license, and shall similarly notify the sales agent when the sales agent license is reinstated following the commissioner's receipt of a withdrawal of the certificate of noncompliance.

(10) Notwithstanding any statutory confidentiality provision, the commissioner may share information with the centralized collection unit of the department of revenue for the sole purpose of identifying sales agents subject to enforcement under Iowa Code chapter 272D.

[ARC 2258C, IAB 11/25/15, effective 12/30/15; ARC 4848C, IAB 1/1/20, effective 2/5/20]

191—100.41(523A) Disciplinary procedures.

100.41(1) Investigations. The commissioner is authorized by Iowa Code sections 17A.13(1) and 523A.803 to conduct such investigations as the commissioner deems necessary to determine whether any person has violated or is about to violate Iowa Code chapter 523A. The commissioner is authorized to issue and enforce subpoenas to compel testimony and to compel the production of books and records, as more fully described in Iowa Code section 523A.803. Upon the commissioner's determination that probable cause exists to commence a disciplinary proceeding, the procedures contained in 191—Chapter 3 shall apply.

100.41(2) Legal relationship of sales agent to preneed seller. For purposes of Iowa Code section 523A.502(1), a sales agent offering preneed services on behalf of a preneed seller is deemed to have a legal relationship as an agent of the preneed seller. The determination of whether a sales agent and a preneed seller have a principal-agent relationship will be made by the commissioner based on the totality of the circumstances surrounding the business relationship.

100.41(3) Factors used to determine whether a preneed seller has agreed to provide merchandise or services.

a. Unless the lack of a mutual agreement has been appropriately documented in the preneed seller's preneed purchaser file records, a preneed seller has agreed "to furnish cemetery merchandise, funeral merchandise, funeral services, or a combination thereof" and received an "initial payment," for purposes of establishing a "purchase agreement," as defined by Iowa Code section 523A.102, if:

(1) A sales agent of the preneed seller has met in person, or had an interactive discussion by telephone or another form of electronic communication, and discussed specific items of merchandise or services and the price of the applicable merchandise or services with a potential purchaser and the potential purchaser did any of the following:

1. Transferred ownership of insurance to the preneed seller,
2. Assigned proceeds of insurance to the preneed seller, or
3. Established a financial account made payable on death to the preneed seller.

(2) A sales agent of the preneed seller has met in person, or had an interactive discussion by telephone or another electronic communication, and discussed specific items of merchandise or services and the applicable prices with the owner of a financial account for which the preneed seller has been

named as the pay-on-death beneficiary to receive funds upon the death of the owner of the financial account.

b. Written documents retained in the preneed seller's records may rebut the presumption that a purchase agreement exists.

100.41(4) Penalties. Persons violating Iowa Code chapter 523A, this chapter, or any associated rules or implementing orders may be subject to one or more of the following penalties.

a. Rescinded IAB 3/10/21, effective 4/14/21.

b. If the commissioner issues or renews a license and subsequently determines that the payment method was declined or returned without payment to the commissioner, the license shall be immediately placed on restricted status until the payments are made and any fees or penalties charged by the commissioner are paid, at which time the license may be reinstated at the request of the applicant.

c. The commissioner may impose the disciplinary sanctions of Iowa Code chapter 523A, and of this chapter, alone or in combination, against a preneed seller or sales agent, or as a condition of licensure of an applicant for a preneed seller license or sales agent license or as a condition of renewal of a license. Sanctions include but are not limited to the following:

- (1) Issuing a warning letter or a letter of reprimand.
- (2) Requiring additional education or training.
- (3) Requiring certain specified procedures or methods of operation.
- (4) Ordering the payment of consumer restitution.
- (5) Placing a licensee on probationary status with or without the imposition of reasonable conditions to control or monitor conduct, such as periodic reports.
- (6) Imposing costs associated with the commissioner's investigation and enforcement activities.
- (7) Imposing any other sanction allowed by law.

d. A person with a restricted or expired license is subject to disciplinary action, injunctive action, criminal sanctions and any other available legal remedies in the event of any violation of Iowa Code chapter 523A, or any rules adopted or orders issued pursuant thereto.

[ARC 2258C, IAB 11/25/15, effective 12/30/15; ARC 5515C, IAB 3/10/21, effective 4/14/21]

These rules are intended to implement Iowa Code chapter 523A.

[Filed ARC 2258C (Notice ARC 2173C, IAB 9/30/15), IAB 11/25/15, effective 12/30/15]

[Filed ARC 2730C (Notice ARC 2667C, IAB 8/3/16), IAB 9/28/16, effective 11/2/16]

[Filed ARC 4848C (Notice ARC 4713C, IAB 10/23/19), IAB 1/1/20, effective 2/5/20]

[Editorial change: IAC Supplement 9/23/20]

[Filed ARC 5515C (Notice ARC 5389C, IAB 1/13/21), IAB 3/10/21, effective 4/14/21]

CHAPTER 112
TERM AND UNIVERSAL LIFE INSURANCE RESERVE FINANCING

191—112.1(521B) Authority. This chapter is promulgated by the commissioner of insurance pursuant to Iowa Code sections 521B.102, 521B.103 and 521B.105.
[ARC 3496C, IAB 12/6/17, effective 1/10/18]

191—112.2(521B) Purpose and intent. The purpose and intent of this chapter is to establish uniform, national standards governing reserve financing arrangements pertaining to life insurance policies containing guaranteed nonlevel gross premiums, life insurance policies containing guaranteed nonlevel benefits, and universal life insurance policies with secondary guarantees; and to ensure that, with respect to each such financing arrangement, funds consisting of primary security and other security, as defined in rule 191—112.5(521B), are held by or on behalf of ceding insurers in the forms and amounts required herein. In general, reinsurance ceded for reserve financing purposes has one or more of the following characteristics: some or all of the assets used to secure the reinsurance treaty or to capitalize the reinsurer (1) are issued by the ceding insurer or its affiliates; or (2) are not unconditionally available to satisfy the general account obligations of the ceding insurer; or (3) create a reimbursement, indemnification or other similar obligation on the part of the ceding insurer or any of its affiliates (other than a payment obligation under a derivative contract acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty).
[ARC 3496C, IAB 12/6/17, effective 1/10/18]

191—112.3(521B) Applicability. This chapter shall apply to reinsurance treaties that cede liabilities pertaining to covered policies, as that term is defined in rule 191—112.5(521B), issued by any life insurance company domiciled in this state. This chapter and rule 191—5.33(510) shall both apply to such reinsurance treaties; provided, that in the event of a direct conflict between a rule of this chapter and rule 191—5.33(510), the rules of this chapter shall apply, but only to the extent necessary in order to resolve the conflict.
[ARC 3496C, IAB 12/6/17, effective 1/10/18]

191—112.4(521B) Exemptions. This chapter does not apply to:

112.4(1) Reinsurance of:

a. Policies that satisfy the criteria for exemption set forth in 191—subrule 47.5(6) or 47.5(7); and which are issued before the later of:

(1) January 10, 2018, and

(2) The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies' statutory reserves, but in no event later than January 1, 2020.

b. Portions of policies that satisfy the criteria for exemption set forth in 191—subrule 47.5(5) and which are issued before the later of:

(1) January 10, 2018, and

(2) The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies' statutory reserves, but in no event later than January 1, 2020.

c. Any universal life policy that meets all of the following requirements:

(1) Secondary guarantee period, if any, is five years or less;

(2) Specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the commissioner's standard ordinary (CSO) valuation tables and valuation interest rate applicable to the issue year of the policy; and

(3) The initial surrender charge is not less than 100 percent of the first year annualized specified premium for the secondary guarantee period.

d. Credit life insurance.

e. Any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

f. Any group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.

112.4(2) Reinsurance ceded to an assuming insurer that meets the applicable requirements of Iowa Code section 521B.102(4).

112.4(3) Reinsurance ceded to an assuming insurer that meets the applicable requirements of Iowa Code sections 521B.102(1) to 521B.102(3), and that, in addition:

a. Prepares statutory financial statements in compliance with the National Association of Insurance Commissioners (NAIC) Accounting Practices and Procedures Manual, without any departures from NAIC statutory accounting practices and procedures pertaining to the admissibility or valuation of assets or liabilities that increase the assuming insurer's reported surplus and are material enough that they need to be disclosed in the financial statement of the assuming insurer pursuant to Statement of Statutory Accounting Principles No. 1 (SSAP 1); and

b. Is not in a company-action-level event, regulatory-action-level event, authorized-control-level event, or mandatory-control-level event as those terms are defined in Iowa Code section 521E.1 et seq. when its risk-based capital (RBC) is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation.

112.4(4) Reinsurance ceded to an assuming insurer that meets the applicable requirements of Iowa Code sections 521B.102(1) to 521B.102(3), and that, in addition:

a. Is not an affiliate of, as that term is defined in Iowa Code section 521A.1(1):

- (1) The insurer ceding the business to the assuming insurer, or
- (2) Any insurer that directly or indirectly ceded the business to that ceding insurer;

b. Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual;

c. Is both:

- (1) Licensed or accredited in at least ten states (including its state of domicile), and
- (2) Not licensed in any state as a captive, special purpose vehicle, special purpose financial captive, special purpose life reinsurance company, limited purpose subsidiary, or any other similar licensing regime; and

d. Is not, or would not be, below 500 percent of the authorized-control-level RBC as that term is defined in Iowa Code section 521E.1(12)“c” when its RBC is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation, and without recognition of any departures from the NAIC statutory accounting practices and procedures pertaining to the admission or valuation of assets or liabilities that increase the assuming insurer's reported surplus.

112.4(5) Reinsurance ceded to an assuming insurer that meets the requirements of Iowa Code section 521B.102(5) pertaining to certain certified reinsurers that meet threshold size and licensing requirements.

112.4(6) Reinsurance not otherwise exempt under subrules 112.4(1) to 112.4(5) if the commissioner, after consulting with the NAIC financial analysis working group (FAWG) or other group of regulators designated by the NAIC, as applicable, determines under all the facts and circumstances that all of the following apply:

a. The risks are clearly outside of the intent and purpose of this chapter (as described in rule 191—112.2(521B)),

b. The risks are included within the scope of this chapter only as a technicality, and

c. The application of this chapter to those risks is not necessary to provide appropriate protection to policyholders. The commissioner shall post on the insurance division's public Website a notice of any decision made pursuant to this subrule to exempt a reinsurance treaty from this chapter, as well as the general basis therefor (including a summary description of the treaty).

[ARC 3496C, IAB 12/6/17, effective 1/10/18]

191—112.5(521B) Definitions.

“*Actuarial method*” means the methodology used to determine the required level of primary security, as described in rule 191—112.6(521B).

“*Covered policies*” means the following: Subject to the exemptions described in rule 191—112.4(521B), covered policies are those policies, other than grandfathered policies, of the following policy types:

1. Life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits or both, except for flexible premium universal life insurance policies; or
2. Flexible premium universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period.

“*Grandfathered policies*” means policies of the types described in the definition of “covered policies” above that were:

1. Issued prior to January 1, 2015; and
2. Ceded, as of December 31, 2014, as part of a reinsurance treaty that would not have met one of the exemptions set forth in rule 191—112.4(521B) had that rule then been in effect.

“*Noncovered policies*” means any policy that does not meet the definition of “covered policies,” including grandfathered policies.

“*Other security*” means any security acceptable to the commissioner other than security meeting the definition of “primary security.”

“*Primary security*” means the following forms of security:

1. Cash meeting the requirements of Iowa Code section 521B.103(2)“a”;
2. Securities listed by the NAIC Securities Valuation Office meeting the requirements of Iowa Code section 521B.103(2)“b,” but excluding any synthetic letter of credit, contingent note, credit-linked note or other similar security that operates in a manner similar to a letter of credit, and excluding any securities issued by the ceding insurer or any of its affiliates; and
3. For security held in connection with funds-withheld and modified coinsurance reinsurance treaties:
 - Commercial loans in good standing of CM3 quality and higher;
 - Policy loans; and
 - Derivatives acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty.

“*Required level of primary security*” means the dollar amount determined by applying the actuarial method to the risks ceded with respect to covered policies, but not more than the total reserve ceded.

“*Valuation manual*” means the valuation manual adopted by the NAIC as described in Iowa Code section 508.36(14)“b”(1), with all amendments adopted by the NAIC that are effective for the financial statement date on which credit for reinsurance is claimed.

“*VM-20*” means “Requirements for Principle-Based Reserves for Life Products,” including all relevant definitions, from the valuation manual.

[ARC 3496C, IAB 12/6/17, effective 1/10/18]

191—112.6(521B) The actuarial method.

112.6(1) The actuarial method that is used to establish the required level of primary security for each reinsurance treaty subject to this chapter shall be VM-20, applied on a treaty-by-treaty basis, including all relevant definitions, from the valuation manual as then in effect, applied as follows:

a. For covered policies described in paragraph “1” of the definition of “covered policies,” the actuarial method is the greater of the deterministic reserve or the net premium reserve (NPR) regardless of whether the criteria for exemption testing can be met. However, if the covered policies do not meet the requirements of the stochastic reserve exclusion test in the valuation manual, then the actuarial method is the greatest of the deterministic reserve, the stochastic reserve, or the NPR. In addition, if such covered policies are reinsured in a reinsurance treaty that also contains covered policies described in paragraph “2” of the definition of “covered policies,” the ceding insurer may elect to instead use paragraph 112.6(1)“b” as the actuarial method for the entire reinsurance agreement. Regardless of whether paragraph 112.6(1)“a” or 112.6(1)“b” is used, the actuarial method must comply with any

requirements or restrictions that the valuation manual imposes when aggregating these policy types for purposes of principle-based reserve calculations.

b. For covered policies described in paragraph “2” of the definition of “covered policies,” the actuarial method is the greatest of the deterministic reserve, the stochastic reserve, or the NPR regardless of whether the criteria for exemption testing can be met.

c. Except as provided in paragraph 112.6(1) “*d*,” the actuarial method is to be applied on a gross basis to all risks with respect to the covered policies as originally issued or assumed by the ceding insurer.

d. If the reinsurance treaty cedes less than 100 percent of the risk with respect to the covered policies, then the required level of primary security may be reduced as follows:

(1) If a reinsurance treaty cedes only a quota share of some or all of the risks pertaining to the covered policies, the required level of primary security, as well as any adjustment under subparagraph 112.6(1) “*d*”(3), may be reduced to a pro rata portion in accordance with the percentage of the risk ceded;

(2) If the reinsurance treaty in a nonexempt arrangement cedes only the risks pertaining to a secondary guarantee, the required level of primary security may be reduced by an amount determined by applying the actuarial method on a gross basis to all risks, other than risks related to the secondary guarantee, pertaining to covered policies, except that for covered policies for which the ceding insurer did not elect to apply the provisions of VM-20 to establish statutory reserves, the required level of primary security may be reduced by the statutory reserve retained by the ceding insurer on those covered policies, provided that the retained reserve of those covered policies shall be reflective of any reduction pursuant to the cession of mortality risk on a yearly renewable term basis in an exempt arrangement;

(3) If a portion of the covered policy risk is ceded to another reinsurer on a yearly renewable term basis in an exempt arrangement, the required level of primary security may be reduced by the amount resulting by applying the actuarial method including the reinsurance section of VM-20 to the portion of the covered policy risks ceded in the exempt arrangement, except that for covered policies issued prior to January 1, 2017, this adjustment is not to exceed $[c_x / (2 * \text{number of reinsurance premiums per year})]$ where c_x is calculated using the same mortality table used in calculating the net premium reserve; and

(4) For any other treaty ceding a portion of risk to a different reinsurer, including but not limited to stop loss, excess of loss and other non-proportional reinsurance treaties, there will be no reduction in the required level of primary security.

It is possible for any combination of subparagraphs 112.6(1) “*d*”(1) to 112.6(1) “*d*”(4) to apply. Such adjustments to the required level of primary security will be done in the sequence that accurately reflects the portion of the risk ceded via the treaty. The ceding insurer shall document the rationale and steps taken to accomplish the adjustments to the required level of primary security due to the cession of less than 100 percent of the risk.

The adjustments for other reinsurance will be made only with respect to reinsurance treaties entered into directly by the ceding insurer. The ceding insurer will make no adjustment as a result of a retrocession treaty entered into by the assuming insurers.

e. In no event will the required level of primary security resulting from application of the actuarial method exceed the amount of statutory reserves ceded.

f. If the ceding insurer cedes risks with respect to covered policies, including any riders, in more than one reinsurance treaty subject to this chapter, in no event will the aggregate required level of primary security for those reinsurance treaties be less than the required level of primary security calculated using the actuarial method as if all risks ceded in those treaties were ceded in a single treaty subject to this chapter.

g. If a reinsurance treaty subject to this chapter cedes risk on both covered and noncovered policies, credit for the ceded reserves shall be determined as follows:

(1) The actuarial method shall be used to determine the required level of primary security for the covered policies, and rule 191—112.7(521B) shall be used to determine the reinsurance credit for the covered policy reserves; and

(2) Credit for the noncovered policy reserves shall be granted only to the extent that security, in addition to the security held to satisfy the requirements of subparagraph 112.6(1) “*g*”(1), is held by or on behalf of the ceding insurer in accordance with Iowa Code sections 521B.102 and 521B.103. Any

primary security used to meet the requirements of this subparagraph may not be used to satisfy the required level of primary security for the covered policies.

112.6(2) For the purposes of both calculating the required level of primary security pursuant to the actuarial method and determining the amount of primary security and other security, as applicable, held by or on behalf of the ceding insurer, the following shall apply:

a. For assets, including any such assets held in trust, that would be admitted under the NAIC Accounting Practices and Procedures Manual if they were held by the ceding insurer, the valuations are to be determined according to statutory accounting procedures as if such assets were held in the ceding insurer's general account and without taking into consideration the effect of any prescribed or permitted practices; and

b. For all other assets, the valuations are to be those that were assigned to the assets for the purpose of determining the amount of reserve credit taken. In addition, the asset spread tables and asset default cost tables required by VM-20 shall be included in the actuarial method if adopted by the NAIC's life actuarial (A) task force no later than the December 31st on or immediately preceding the valuation date for which the required level of primary security is being calculated. The tables of asset spreads and asset default costs shall be incorporated into the actuarial method in the manner specified in VM-20.

[ARC 3496C, IAB 12/6/17, effective 1/10/18]

191—112.7(521B) Requirements applicable to covered policies to obtain credit for reinsurance; opportunity for remediation.

112.7(1) Subject to the exemptions described in rule 191—112.4(521B) and the provisions of subrule 112.7(2), credit for reinsurance shall be allowed with respect to ceded liabilities pertaining to covered policies pursuant to Iowa Code sections 521B.102 and 521B.103 if, and only if, in addition to all other requirements imposed by law or rules, the following requirements are met on a treaty-by-treaty basis:

a. The ceding insurer's statutory policy reserves with respect to the covered policies are established in full and in accordance with the applicable requirements of Iowa Code section 508.36 and related rules and actuarial guidelines, and credit claimed for any reinsurance treaty subject to this chapter does not exceed the proportionate share of those reserves ceded under the contract; and

b. The ceding insurer determines the required level of primary security with respect to each reinsurance treaty subject to this chapter and provides support for its calculation as determined to be acceptable to the commissioner; and

c. Funds consisting of primary security, in an amount at least equal to the required level of primary security, are held by or on behalf of the ceding insurer, as security under the reinsurance treaty within the meaning of Iowa Code section 521B.103, on a funds-withheld, trust, or modified coinsurance basis; and

d. Funds consisting of other security, in an amount at least equal to any portion of the statutory reserves as to which primary security is not held pursuant to paragraph 112.7(1)"c," are held by or on behalf of the ceding insurer as security under the reinsurance treaty within the meaning of Iowa Code section 521B.103; and

e. Any trust used to satisfy the requirements of rule 191—112.7(521B) shall comply with all of the conditions and qualifications of 191—subrule 5.33(11), except that:

(1) Funds consisting of primary security or other security held in trust shall, for the purposes identified in subrule 112.6(2), be valued according to the valuation rules set forth in subrule 112.6(2), as applicable; and

(2) There are no affiliate investment limitations with respect to any security held in such trust if such security is not needed to satisfy the requirements of paragraph 112.7(1)"c"; and

(3) The reinsurance treaty must prohibit withdrawals or substitutions of trust assets that would leave the fair market value of the primary security within the trust (when aggregated with primary security outside the trust that is held by or on behalf of the ceding insurer in the manner required by paragraph 112.7(1)"c") below 102 percent of the level required by paragraph 112.7(1)"c" at the time of the withdrawal or substitution; and

(4) The determination of reserve credit under 191—subparagraphs 5.33(11)“d”(3) to 5.33(11)“d”(5) shall be determined according to the valuation rules set forth in subrule 112.6(2), as applicable; and

f. The reinsurance treaty has been approved by the commissioner.

112.7(2) Requirements at inception date and on an ongoing basis; remediation.

a. The requirements of subrule 112.7(1) must be satisfied as of the date that risks under covered policies are ceded (if such date is on or after January 10, 2018) and on an ongoing basis thereafter. Under no circumstances shall a ceding insurer take or consent to any action or series of actions that would result in a deficiency under paragraph 112.7(1)“c” or 112.7(1)“d” with respect to any reinsurance treaty under which covered policies have been ceded, and in the event that a ceding insurer becomes aware at any time that such a deficiency exists, it shall use its best efforts to arrange for the deficiency to be eliminated as expeditiously as possible.

b. Prior to the due date of each quarterly or annual statement, each life insurance company that has ceded reinsurance within the scope of rule 191—112.3(521B) shall perform an analysis, on a treaty-by-treaty basis, to determine, as to each reinsurance treaty under which covered policies have been ceded, whether as of the end of the immediately preceding calendar quarter (the valuation date) the requirements of paragraphs 112.7(1)“c” and 112.7(1)“d” were satisfied. The ceding insurer shall establish a liability equal to the excess of the credit for reinsurance taken over the amount of primary security actually held pursuant to paragraph 112.7(1)“c,” unless either:

(1) The requirements of paragraphs 112.7(1)“c” and 112.7(1)“d” were fully satisfied as of the valuation date as to such reinsurance treaty; or

(2) Any deficiency has been eliminated before the due date of the quarterly or annual statement to which the valuation date relates through the addition of primary security or other security or both, as the case may be, in such amount and in such form as would have caused the requirements of paragraphs 112.7(1)“c” and 112.7(1)“d” to be fully satisfied as of the valuation date.

c. Nothing in paragraph 112.7(2)“b” shall be construed to allow a ceding company to maintain any deficiency under paragraph 112.7(1)“c” or 112.7(1)“d” for any period of time longer than is reasonably necessary to eliminate the deficiency.

[ARC 3496C, IAB 12/6/17, effective 1/10/18; ARC 5514C, IAB 3/10/21, effective 4/14/21]

191—112.8(521B) Severability. If any provision of this chapter shall be held invalid, the remainder of the chapter shall not be affected.

[ARC 3496C, IAB 12/6/17, effective 1/10/18]

191—112.9(521B) Prohibition against avoidance. No insurer that has covered policies as to which this chapter applies, as set forth in rule 191—112.3(521B), shall take any action or series of actions, or enter into any transaction or arrangement or series of transactions or arrangements, if the purpose of such action, transaction or arrangement or series thereof is to avoid the requirements of this chapter, or to circumvent its purpose and intent, as set forth in rule 191—112.2(521B).

[ARC 3496C, IAB 12/6/17, effective 1/10/18]

These rules are intended to implement Iowa Code sections 521B.102, 521B.103, and 521B.105.

[Filed ARC 3496C (Notice ARC 3362C, IAB 10/11/17), IAB 12/6/17, effective 1/10/18]

[Filed ARC 5514C (Notice ARC 5388C, IAB 1/13/21), IAB 3/10/21, effective 4/14/21]

CHAPTER 102
ENTREPRENEUR INVESTMENT AWARDS PROGRAM

261—102.1(15E) Authority. The authority for adopting rules establishing the entrepreneur investment awards program under this chapter is provided in Iowa Code sections 15.106A and 15E.362.
[ARC 0611C, IAB 2/20/13, effective 3/27/13; ARC 2501C, IAB 4/27/16, effective 6/1/16]

261—102.2(15E) Purpose. The purpose of the entrepreneur investment awards program is to provide financial assistance to service providers that provide technical and financial assistance to entrepreneurs and start-up companies seeking to create, locate, or expand a business in the state.
[ARC 0611C, IAB 2/20/13, effective 3/27/13; ARC 2501C, IAB 4/27/16, effective 6/1/16]

261—102.3(15E) Definitions. As used in this chapter, unless the context otherwise requires:

“*Applicant*” means a person applying to the authority for financial assistance under the program.

“*Authority*” means the economic development authority created in Iowa Code section 15.105.

“*Board*” means the members of the economic development authority appointed by the governor and in whom the powers of the authority are vested pursuant to Iowa Code section 15.105.

“*Business development services*” includes but is not limited to corporate development services, business model development services, business planning services, marketing services, financial strategies and management services, mentoring and management coaching, and networking services.

“*Committee*” means a committee of application reviewers appointed by the director.

“*Deliverables*” means the performance of duties or other obligations required of an applicant under a contract entered into with the authority in consideration for the receipt of financial assistance under the program. At a minimum, “deliverables” includes the continued maintenance of all initial eligibility requirements for the duration of a contract entered into under the program and may include such other terms and conditions as the authority deems necessary to effectuate the legislative intent of the program or to protect the interest of taxpayers.

“*Director*” means the director of the authority.

“*Eligible entrepreneurial assistance provider*” or “*service provider*” means a person meeting the requirements of rule 261—102.6(15E).

“*Financial assistance*” means the same as defined in Iowa Code section 15.327.

“*Fund*” means the entrepreneur investment awards program fund created pursuant to Iowa Code section 15E.363.

“*Iowa-based business*” means a service provider whose principal place of operations is in Iowa and that is actively providing business development services in the state.

“*Operating costs*” means the expenses associated with administering a service provider’s activities on a day-to-day basis. “Operating costs” includes both fixed costs and variable costs. “Operating costs” does not include expenses associated with non-operating activities such as interest expenses, repayment of principal, or moneys invested by the service provider in clients’ businesses or in other ventures.

“*Program*” means the entrepreneur investment awards program established pursuant to Iowa Code section 15E.362.

[ARC 0611C, IAB 2/20/13, effective 3/27/13; ARC 2501C, IAB 4/27/16, effective 6/1/16; ARC 5513C, IAB 3/10/21, effective 4/14/21]

261—102.4(15E) Program description, application procedures, and delegation of functions.

102.4(1) Program description. The program is designed to provide financial assistance to service providers meeting the eligibility requirements described in rule 261—102.6(15E). All awards of financial assistance must ultimately be approved by the board, and a contract must be entered into before funds will be disbursed. All contracts will specify the deliverables required in consideration for the provision of financial assistance.

102.4(2) Application and award procedures. Eligible service providers may submit applications to the authority. The applications will receive an initial review to confirm program eligibility before being sent to the committee for a recommendation on funding. The committee will provide its recommendation

to the board for a final determination on funding. The board may approve, deny, or defer each application for financial assistance under the program. The board will consider applications for financial assistance during the annual filing window described in subrule 102.4(4). The amount of financial assistance awarded to a service provider is within the discretion of the authority as determined by the board. If the board approves an award of financial assistance for a service provider, the authority will prepare a required contract specifying the terms and conditions under which financial assistance is provided to the service provider.

102.4(3) Review procedure.

a. The committee shall verify that all objective criteria for eligibility are met as described in subrule 102.6(1) and shall provide an opinion as to whether and to what extent the applicant meets the subjective criteria described in subrule 102.6(2). The analysis of eligibility shall be compiled in report form and submitted to the board for its use in making a final determination.

b. The committee shall recommend to the authority the terms and conditions to be included in the contract in consideration for receipt of the grant funds.

102.4(4) Annual filing window. In order to facilitate the competitive application and scoring process described in rule 261—102.6(15E), applications will be accepted only during the established application period, or periods, as identified by the authority on its website during each fiscal year in which funding is available. The authority may adjust the filing window dates under extenuating circumstances and will notify affected parties of such circumstances.

102.4(5) Miscellaneous. The authority may contract with outside service providers for assistance with the program. The authority may also make client referrals to eligible service providers regardless of the amount of financial assistance provided.

[ARC 0611C, IAB 2/20/13, effective 3/27/13; ARC 2501C, IAB 4/27/16, effective 6/1/16; ARC 5513C, IAB 3/10/21, effective 4/14/21]

261—102.5(15E) Program funding.

102.5(1) Aggregate fiscal year limitation. The authority will not award more than \$1 million in financial assistance under the program in any one fiscal year.

102.5(2) Individual applicant limitation. The authority will negotiate the amount of financial assistance to be provided to a service provider. However, the authority will not award more than \$200,000 to any one service provider in any one fiscal year.

102.5(3) Program funding source and allocation. Moneys for financial assistance under the program will be awarded from the moneys in the entrepreneur investment awards program fund created pursuant to Iowa Code section 15E.363. Moneys are deposited in this fund by the authority pursuant to Iowa Code section 15.335B. The amount deposited each year depends on the amount allocated for such purposes under Iowa Code section 15.335B.

102.5(4) Use of funds. An applicant receiving financial assistance under the program shall only use the funds for the purpose of defraying operating costs actually incurred by the service provider in providing business development services to emerging and early-stage innovation companies in this state. Financial assistance provided under the program shall not be distributed to owners or investors of the company to which business development services are provided and shall not be distributed to other persons assisting in the provision of business development services.

[ARC 0611C, IAB 2/20/13, effective 3/27/13; ARC 2501C, IAB 4/27/16, effective 6/1/16]

261—102.6(15E) Eligibility requirements and competitive scoring process.

102.6(1) Eligibility. In order to be eligible for financial assistance under the program, an applicant must meet the requirements of this rule. A service provider applying to the program must meet all of the following criteria for eligibility:

a. The service provider must have its principal place of operations located in this state.

b. The service provider must offer a comprehensive set of business development services to emerging and early-stage innovation companies to assist in the creation, location, growth, and long-term success of the company in this state.

c. The business development services may be performed at the physical location of the service provider or the company.

d. The business development services may be provided in consideration of equity participation in the company, a fee for services, a membership agreement with the company, or any combination thereof.

102.6(2) *Competitive scoring criteria.* The authority will award financial assistance on a competitive basis. In making awards of financial assistance, the authority will consider the following criteria:

a. The business experience of the professional staff employed or retained by the service provider. 25 points.

b. The business plan review capacity of the professional staff of the service provider. 15 points.

c. The expertise in all aspects of business disciplines of the professional staff of the service provider. 15 points.

d. The access of the service provider to external service providers, including legal, accounting, marketing, and financial services. 15 points.

e. The service model and likelihood of success of the service provider and its similarity to other successful service providers in the country. 15 points.

f. The financial need of the service provider. 15 points.

[ARC 0611C, IAB 2/20/13, effective 3/27/13; ARC 2501C, IAB 4/27/16, effective 6/1/16]

261—102.7(15E) Contract and report information required.

102.7(1) *Contract required.* An applicant awarded financial assistance under the program shall enter into a contract with the authority for the receipt of such funds. The authority will include certain deliverables in the contract as recommended by the committee. The authority will track and monitor all contract provisions including an analysis of whether the service provider's deliverables meet all requirements of the contract and including an evaluation of the value added by the service provider to the businesses of entrepreneurs. The authority will make the final determination as to compliance with the terms of the contract and will make the final determination as to whether and when to disburse funds to the applicant.

102.7(2) *Reporting information required.* Under Iowa Code section 15E.362, the authority is required to report on the success of the program to the legislature. An applicant may be required to submit all information necessary for the authority to produce such a report. The authority may include terms in the required contract effectuating this requirement.

[ARC 0611C, IAB 2/20/13, effective 3/27/13; ARC 2501C, IAB 4/27/16, effective 6/1/16; ARC 5513C, IAB 3/10/21, effective 4/14/21]

These rules are intended to implement Iowa Code sections 15E.362 and 15E.363.

[Filed ARC 0611C (Notice ARC 0408C, IAB 10/17/12), IAB 2/20/13, effective 3/27/13]

[Filed ARC 2501C (Notice ARC 2374C, IAB 1/20/16), IAB 4/27/16, effective 6/1/16]

[Filed ARC 5513C (Notice ARC 5386C, IAB 1/13/21), IAB 3/10/21, effective 4/14/21]

CHAPTER 78
AMOUNT, DURATION AND SCOPE OF
MEDICAL AND REMEDIAL SERVICES

[Prior to 7/1/83, Social Services[770] Ch 78]

[Prior to 2/11/87, Human Services[498]]

441—78.1(249A) Physicians' services. Payment will be approved for all medically necessary services and supplies provided by the physician including services rendered in the physician's office or clinic, the home, in a hospital, nursing home or elsewhere.

Payment shall be made for all services rendered by a doctor of medicine or osteopathy within the scope of this practice and the limitations of state law subject to the following limitations and exclusions:

78.1(1) Payment will not be made for:

a. Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner) unless it is established that there is no licensed retail pharmacy in the community in which the legally qualified practitioner's office is maintained. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the state department of public health.

b. Routine physical examinations. Rescinded IAB 8/1/07, effective 8/1/07.

c. Treatment of certain foot conditions as specified in 78.5(2) "a," "b," and "c."

d. Acupuncture treatments.

e. Rescinded 9/6/78.

f. Unproven or experimental medical and surgical procedures. The criteria in effect in the Medicare program shall be utilized in determining when a given procedure is unproven or experimental in nature.

g. Charges for surgical procedures on the "Outpatient/Same Day Surgery List" produced by the IME medical services unit or associated inpatient care charges when the procedure is performed in a hospital on an inpatient basis unless the physician has secured approval from the hospital's utilization review department prior to the patient's admittance to the hospital. Approval shall be granted only when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The "Outpatient/Same Day Surgery List" shall be published by the department in the provider manuals for hospitals and physicians. The "Outpatient/Same Day Surgery List" shall be developed by the IME medical services unit and shall include procedures which can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. The IME medical services unit may add, delete, or modify entries on the "Outpatient/Same Day Surgery List."

h. Elective, non-medically necessary cesarean section (C-section) deliveries.

78.1(2) Drugs and supplies may be covered when prescribed by a legally qualified practitioner as provided in this rule.

a. Drugs are covered as provided by rule 441—78.2(249A).

b. Medical supplies are payable when ordered by a legally qualified practitioner for a specific rather than incidental use, subject to the conditions specified in rule 441—78.10(249A). When a member is receiving care in a nursing facility or residential care facility, payment will be approved only for the following supplies when prescribed by a legally qualified practitioner:

(1) Colostomy and ileostomy appliances.

(2) Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

(7) Diabetic supplies including needles and syringes, blood glucose test strips, and diabetic urine test supplies.

c. Prescription records are required for all drugs as specified in Iowa Code sections 124.308, 155A.27 and 155A.29. For the purposes of the medical assistance program, prescriptions for medical supplies are required and shall be subject to the same provisions.

d. Rescinded IAB 1/30/08, effective 4/1/08.

e. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a physician must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

f. Nonprescription drugs. Rescinded IAB 1/30/08, effective 4/1/08.

78.1(3) Payment will be approved for injections provided they are reasonable, necessary, and related to the diagnosis and treatment of an illness or injury. When billing for an injection, the legally qualified practitioner must specify the brand name of the drug and the manufacturer, the strength of the drug, the amount administered, and the charge of each injection. When the strength and dosage of the drug is not included, payment will be made based on the customary dosage. The following exclusions are applicable.

a. Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

b. Payment will not be approved for an injection when administered for a reason other than the treatment of a particular condition, illness, or injury. When injecting an amphetamine or legend vitamin, prior approval must be obtained as specified in 78.1(2)“a”(3).

c. Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

d. Allergenic extract materials provided the patient for self-administration shall not exceed a 90-day supply.

e. Payment will not be approved when an injection is determined to fall outside of what is medically reasonable or necessary based on basic standards of medical practice for the required level of care for a particular condition.

f. Payment for vaccines available through the Vaccines for Children (VFC) Program will be approved only if the VFC program stock has been depleted.

g. Payment will not be approved for injections of “covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any “Part D eligible individual” as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

78.1(4) For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery which can be expected primarily to improve physical appearance or which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions. When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subrule. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage.

a. Coverage under the program is generally not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

(1) Correction of a congenital anomaly; or

(2) Restoration of body form following an accidental injury; or

(3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.

(4) Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration for exception will be given to cases involving children who may require a growth period.

b. Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

(1) Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.

(2) Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.

(3) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.

(4) Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implant procedures, and surgeries for the purpose of sex reassignment.

c. When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for coverage under the program, all related services and supplies, including any institutional costs, are also excluded.

d. Following is a partial list of cosmetic, reconstructive, or plastic surgery procedures which are not covered under the program. This list is for example purposes only and is not considered all inclusive.

(1) Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.

(2) Cosmetic, reconstructive, or plastic surgical procedures which are justified primarily on the basis of a psychological or psychiatric need.

(3) Augmentation mammoplasties.

(4) Face lifts and other procedures related to the aging process.

(5) Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts.

(6) Panniculectomy and body sculpture procedures.

(7) Repair of sagging eyelids, unless there is demonstrated and medically documented significant impairment of vision.

(8) Rhinoplasties, unless there is evidence of accidental injury occurring within the past six months which resulted in significant obstruction of breathing.

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

(11) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

e. Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident or treatment, but only when the subsequent complications represent a separate medical condition such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions. Coverage shall not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial noncovered care. An example of a complication similar to the initial period of care would be repair of facial scarring resulting from dermabrasion for acne.

78.1(5) The legally qualified practitioner's prescription for medical equipment, appliances, or prosthetic devices shall include the patient's diagnosis and prognosis, the reason the item is required, and an estimate in months of the duration of the need. Payment will be made in accordance with rule 78.10(249A).

78.1(6) Payment will be approved for the examination to establish the need for orthopedic shoes in accordance with rule 441—78.15(249A).

78.1(7) No payment shall be made for the services of a private duty nurse.

78.1(8) Payment for mileage shall be the same as that in effect in part B of Medicare.

78.1(9) Payment will be approved for visits to patients in nursing facilities subject to the following conditions:

a. Payment will be approved for only one visit to the same patient in a calendar month. Payment for further visits will be made only when the need for the visits is adequately documented by the physician.

b. When only one patient is seen in a single visit the allowance shall be based on a follow-up home visit. When more than one patient is seen in a single visit, payment shall be based on a follow-up office visit. In the absence of information on the claim, the carrier will assume that more than one patient was seen, and payment approved on that basis.

c. Payment will be approved for mileage in connection with nursing home visits when:

- (1) It is necessary for the physician to travel outside the home community, and
- (2) There are not physicians in the community in which the nursing home is located.

d. Payment will be approved for tasks related to a resident receiving nursing facility care which are performed by a nurse practitioner, clinical nurse specialist, or physician assistant as specified in 441—paragraph 81.13(13) “*e.*” On-site supervision of the physician is not required for these services.

78.1(10) Payment will be approved in independent laboratory when it has been certified as eligible to participate in Medicare.

78.1(11) Rescinded, effective 8/1/87.

78.1(12) Payment will be made on the same basis as in Medicare for services associated with treatment of chronic renal disease including physician’s services, hospital care, renal transplantation, and hemodialysis, whether performed on an inpatient or outpatient basis. Payment will be made for deductibles and coinsurance for those persons eligible for Medicare.

78.1(13) Payment will be made to the physician for services rendered by auxiliary personnel employed by the physician and working under the direct personal supervision of the physician, when such services are performed incident to the physician’s professional service.

a. Auxiliary personnel are nurses, psychologists, social workers, audiologists, occupational therapists and physical therapists.

b. An auxiliary person is considered to be an employee of the physician if the physician:

- (1) Is able to control the manner in which the work is performed, i.e., is able to control when, where and how the work is done. This control need not be actually exercised by the physician.
- (2) Sets work standards.
- (3) Establishes job description.
- (4) Withholds taxes from the wages of the auxiliary personnel.

c. Direct personal supervision in the office setting means the physician must be present in the same office suite, not necessarily the same room, and be available to provide immediate assistance and direction.

Direct personal supervision outside the office setting, such as the member’s home, hospital, emergency room, or nursing facility, means the physician must be present in the same room as the auxiliary person.

Advanced registered nurse practitioners certified under board of nursing rules in 655—Chapter 7 performing services within their scope of practice are exempt from the direct personal supervision requirement for the purpose of reimbursement to the employing physicians. In these exempted circumstances, the employing physicians must still provide general supervision and be available to provide immediate needed assistance by telephone. Advanced registered nurse practitioners who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

A physician assistant licensed under board of physician assistants’ professional licensure rules in 645—Chapters 326 to 329 is exempt from the direct personal supervision requirement except as expressly required by Iowa Code chapter 148C or required by rules in 645—Chapters 326 to 329. A physician shall be accessible at all times for consultation with a physician assistant unless the physician assistant is providing emergency medical services pursuant to 645—paragraph 327.1(2) “*n.*” Physician assistants who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician's professional service to the member. If the physician has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

78.1(14) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a physician for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.1(15) The certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance record is sufficient for the original certification.

78.1(16) No payment will be made for sterilization of an individual under the age of 21 or who is mentally incompetent or institutionalized. Payment will be made for sterilization performed on an individual who is aged 21 or older at the time the informed consent is obtained and who is mentally competent and not institutionalized when all the conditions in this subrule are met.

a. The following definitions are pertinent to this subrule:

(1) Sterilization means any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing and which is not a necessary part of the treatment of an existing illness or medically indicated as an accompaniment of an operation on the genital urinary tract. Mental illness or retardation is not considered an illness or injury.

(2) Hysterectomy means a medical procedure or operation to remove the uterus.

(3) Mentally incompetent individual means a person who has been declared mentally incompetent by a federal, state or local court of jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

(4) Institutionalized individual means an individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or an individual who is confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

b. The sterilization shall be performed as the result of a voluntary request for the services made by the person on whom the sterilization is performed. The person's consent for sterilization shall be documented on:

(1) Form 470-0835 or 470-0835(S), Consent Form, or

(2) An official sterilization consent form from another state's Medicaid program that contains all information found on the Iowa form and complies with all applicable federal regulations.

c. The person shall be advised prior to the receipt of consent that no benefits provided under the medical assistance program or other programs administered by the department may be withdrawn or withheld by reason of a decision not to be sterilized.

d. The person shall be informed that the consent can be withheld or withdrawn any time prior to the sterilization without prejudicing future care and without loss of other project or program benefits.

e. The person shall be given a complete explanation of the sterilization. The explanation shall include:

(1) A description of available alternative methods and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure.

(2) A thorough description of the specific sterilization procedure to be performed and benefits expected.

(3) A description of the attendant discomforts and risks including the type and possible effects of any anesthetic to be used.

(4) An offer to answer any inquiries the person to be sterilized may have concerning the procedure to be performed. The individual shall be provided a copy of the informed consent form in addition to the oral presentation.

f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent except in the case of premature delivery or emergency abdominal surgery which occurs not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

g. The information in paragraphs “*b*” through “*f*” shall be effectively presented to a blind, deaf, or otherwise handicapped individual and an interpreter shall be provided when the individual to be sterilized does not understand the language used on the consent form or used by the person obtaining consent. The individual to be sterilized may have a witness of the individual’s choice present when consent is obtained.

h. The consent form described in paragraph 78.1(16) “*b*” shall be attached to the claim for payment and shall be signed by:

- (1) The person to be sterilized,
- (2) The interpreter, when one was necessary,
- (3) The physician, and
- (4) The person who provided the required information.

i. Informed consent shall not be obtained while the individual to be sterilized is:

- (1) In labor or childbirth, or
- (2) Seeking to obtain or obtaining an abortion, or
- (3) Under the influence of alcohol or other substance that affects the individual’s state of awareness.

j. Payment will be made for a medically necessary hysterectomy only when it is performed for a purpose other than sterilization and only when one or more of the following conditions is met:

(1) The individual or representative has signed an acknowledgment that she has been informed orally and in writing from the person authorized to perform the hysterectomy that the hysterectomy will make the individual permanently incapable of reproducing, or

(2) The individual was already sterile before the hysterectomy, the physician has certified in writing that the individual was already sterile at the time of the hysterectomy and has stated the cause of the sterility, or

(3) The hysterectomy was performed as a result of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible and the physician includes a description of the nature of the emergency.

78.1(17) Abortions. Payment for an abortion or related service is made when Form 470-0836 is completed for the applicable circumstances and is attached to each claim for services. Payment for an abortion is made under one of the following circumstances:

a. The physician certifies that the pregnant woman’s life would be endangered if the fetus were carried to term.

b. The physician certifies that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and the physician states the medical indication for determining the fetal condition.

c. The pregnancy was the result of rape reported to a law enforcement agency or public or private health agency which may include a family physician within 45 days of the date of occurrence of the incident. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of the rape.

d. The pregnancy was the result of incest reported to a law enforcement agency or public or private health agency including a family physician no later than 150 days after the date of occurrence. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of incest.

78.1(18) Payment and procedure for obtaining eyeglasses, contact lenses, and visual aids, shall be the same as described in 441—78.6(249A). (Cross reference 78.28(4))

78.1(19) Preprocedure review by the IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the IME medical services unit and the

department. If not so approved by the IME medical services unit, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from the IME medical services unit.

78.1(20) Transplants.

a. Payment will be made only for the following organ and tissue transplant services:

(1) Kidney, cornea, skin, and bone transplants.

(2) Allogeneic stem cell transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease (SCID), Wiskott-Aldrich syndrome, follicular lymphoma, Fanconi anemia, paroxysmal nocturnal hemoglobinuria, pure red cell aplasia, amegakaryocytosis/congenital thrombocytopenia, beta thalassemia major, sickle cell disease, Hurler's syndrome (mucopolysaccharidosis type 1 [MPS-1]), adrenoleukodystrophy, metachromatic leukodystrophy, refractory anemia, agnogenic myeloid metaplasia (myelofibrosis), familial erythrophagocytic lymphohistiocytosis and other histiocytic disorders, acute myelofibrosis, Diamond-Blackfan anemia, epidermolysis bullosa, or the following types of leukemia: acute myelocytic leukemia, chronic myelogenous leukemia, juvenile myelomonocytic leukemia, chronic myelomonocytic leukemia, acute myelogenous leukemia, and acute lymphocytic leukemia.

(3) Autologous stem cell transplants for treatment of the following conditions: acute leukemia; chronic lymphocytic leukemia; plasma cell leukemia; non-Hodgkin's lymphomas; Hodgkin's lymphoma; relapsed Hodgkin's lymphoma; lymphomas presenting poor prognostic features; follicular lymphoma; neuroblastoma; medulloblastoma; advanced Hodgkin's disease; primitive neuroendocrine tumor (PNET); atypical/rhabdoid tumor (ATRT); Wilms' tumor; Ewing's sarcoma; metastatic germ cell tumor; or multiple myeloma.

(4) Liver transplants for persons with extrahepatic biliary atresia or any other form of end-stage liver disease, except that coverage is not provided for persons with a malignancy extending beyond the margins of the liver.

Liver transplants require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) "f")

Covered liver transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(5) Heart transplants for persons with inoperable congenital heart defects, heart failure, or related conditions. Artificial hearts and ventricular assist devices as a temporary life-support system until a human heart becomes available for transplants are covered. Artificial hearts and ventricular assist devices as a permanent replacement for a human heart are not covered. Heart-lung transplants are covered where bilateral or unilateral lung transplantation with repair of a congenital cardiac defect is contraindicated.

Heart transplants, heart-lung transplants, artificial hearts, and ventricular assist devices described above require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) "f") Covered heart transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(6) Lung transplants. Lung transplants for persons having end-stage pulmonary disease. Lung transplants require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) "f") Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10). Heart-lung transplants are covered consistent with criteria in subparagraph (5) above.

(7) Pancreas transplants for persons with type I diabetes mellitus, as follows:

1. Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.

2. Pancreas transplants alone are covered for persons exhibiting any of the following:

- A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.

- Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.

- Consistent failure of insulin-based management to prevent acute complications.

The pancreas transplants listed under this subparagraph require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) "f")

Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

Transplantation of islet cells or partial pancreatic tissue is not covered.

b. Donor expenses incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery. Expenses of searching for a donor are not covered.

c. All transplants must be medically necessary and meet other general requirements of this chapter for physician and hospital services.

d. Payment will not be made for any transplant not specifically listed in paragraph “*a.*”

78.1(21) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. For the purposes of utilization review, the term “physician” does not include a psychiatrist. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.1(22) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member’s pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. Enhanced services include health education, social services, nutrition education, and a postpartum home visit. Additional reimbursement shall be provided for obstetrical services related to a high-risk pregnancy. (See description of enhanced services at subrule 78.25(3).)

78.1(23) EPSDT care coordination. Rescinded IAB 12/3/08, effective 2/1/09.

78.1(24) Topical fluoride varnish. Payment shall be made for application of an FDA-approved topical fluoride varnish, as defined by the current version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association, for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians or other appropriately licensed practitioners under the supervision of or in collaboration with a physician and who are acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:

a. Application of topical fluoride varnish must be provided in conjunction with an early and periodic screening, diagnosis, and treatment (EPSDT) examination which includes a limited oral screening.

b. Separate payment shall be available only for application of topical fluoride varnish, which shall be at the same rate of reimbursement paid to dentists for providing this service. Separate payment for the limited oral screening shall not be available, as this service is already part of and paid under the EPSDT screening examination.

c. Parents, legal guardians, or other authorized caregivers of children receiving application of topical fluoride varnish as part of an EPSDT screening examination shall be informed by the physician or auxiliary staff employed by and under the physician’s supervision that this application is not a substitute for comprehensive dental care.

d. Physicians rendering the services under this subrule shall make every reasonable effort to refer or facilitate referral of these children for comprehensive dental care rendered by a dental professional.

78.1(25) Prior authorization for medication-assisted treatment shall be governed pursuant to subrule 78.28(2).

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 8714B**, IAB 5/5/10, effective 5/1/10; **ARC 0065C**, IAB 4/4/12, effective 6/1/12; **ARC 0305C**, IAB 9/5/12, effective 11/1/12; **ARC 0846C**, IAB 7/24/13, effective 7/1/13; **ARC 1052C**, IAB 10/2/13, effective 11/6/13; **ARC 1297C**, IAB 2/5/14, effective 4/1/14; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 4899C**, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; **ARC 5418C**, IAB 2/10/21, effective 4/1/21]

441—78.2(249A) Prescribed outpatient drugs. Payment will be made for “covered outpatient drugs” as defined in 42 U.S.C. Section 1396r-8(k)(2)-(4) subject to the conditions and limitations specified in this rule.

78.2(1) Qualified prescriber. All drugs are covered only if prescribed or ordered by an Iowa Medicaid-enrolled practitioner licensed or registered to prescribe as specified in Iowa Code section 155A.3(38).

78.2(2) Prescription required. As a condition of payment for all drugs, including “nonprescription” or “over-the-counter” drugs that may otherwise be dispensed without a prescription or drug order, a prescription or drug order shall be transmitted as specified in Iowa Code sections 124.308, 155A.3 and 155A.27 by the practitioner to the pharmacy, subject to the provisions of Iowa Code section 155A.29 regarding refills. All prescriptions or drug orders shall be available for audit by the department.

78.2(3) Qualified source. All drugs are covered only if marketed by manufacturers that have signed a Medicaid rebate agreement with the Secretary of Health and Human Services in accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990).

78.2(4) Prescription drugs. Drugs that may be dispensed only upon a prescription are covered subject to the following limitations.

a. Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

(1) For any drug requiring prior authorization, reimbursement will be made for a 72-hour or three-day supply dispensed in an emergency when a prior authorization request cannot be submitted.

(2) Unless the manufacturer or labeler of a mental health prescription drug that has a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class enters into a contract to provide the state with a supplemental rebate, the drug may be placed on the preferred drug list as nonpreferred, with prior authorization required. However, prior authorization shall not be required for such a drug for a member whose regimen on the drug was established before January 1, 2011, as verified by documented pharmacy claims.

(3) For mental health prescription drugs requiring prior authorization that have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class, reimbursement will be made for up to a seven-day supply pending prior authorization. A request for prior authorization shall be deemed approved if the prescriber:

1. Has on file with the department current contact information, including a current fax number, and a signed Form 470-4914, Fax Confidentiality Certificate, and

2. Does not receive a notice of approval or disapproval within 48 hours of a request for prior authorization.

(4) Prior authorization for medication-assisted treatment shall be governed pursuant to subrule 78.28(2).

b. Payment is not made for:

(1) Drugs whose prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act.

(2) Drugs used for anorexia, weight gain, or weight loss.

(3) Drugs used for cosmetic purposes or hair growth.

(4) Rescinded IAB 2/8/12, effective 3/14/12.

(5) Otherwise covered outpatient drugs if the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer’s designee.

(6) Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations (drugs identified through the Drug Efficacy Study Implementation (DESI) review)).

(7) “Covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any “Part D eligible individual” as defined by 42 U.S.C. Section 1395w-101(a)(3)(A), including a member who is not enrolled in a Medicare Part D plan.

(8) Drugs prescribed for fertility purposes.

(9) Drugs used for the treatment of sexual or erectile dysfunction, except when used to treat a condition other than sexual or erectile dysfunction for which the drug has been approved by the U.S. Food and Drug Administration.

(10) Prescription drugs for which the prescription was executed in written (and nonelectronic) form unless the prescription was executed on a tamper-resistant pad, as required by Section 1903(i)(23) of the Social Security Act (42 U.S.C. Section 1396b(i)(23)).

(11) Drugs used for symptomatic relief of cough and colds, except for nonprescription drugs listed at subrule 78.2(5).

(12) Investigational drugs, including drugs that are the subject of an investigational new drug (IND) application allowed to proceed by the U.S. Food and Drug Administration (FDA) but that do not meet the definition of a covered outpatient drug in 42 U.S.C. 1396r-8(k)(2)-(4).

78.2(5) Nonprescription drugs.

a. The following drugs that may otherwise be dispensed without a prescription are covered subject to the prior authorization requirements stated below and as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

Acetaminophen tablets 325 mg, 500 mg
Acetaminophen elixir 160 mg/5 ml
Acetaminophen solution 100 mg/ml
Acetaminophen suppositories 120 mg
Artificial tears ophthalmic solution
Artificial tears ophthalmic ointment
Aspirin tablets 81 mg, chewable
Aspirin tablets 81 mg, 325 mg, and 650 mg oral
Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg
Aspirin tablets, buffered 325 mg
Bacitracin ointment 500 units/gm
Benzoyl peroxide 5%, gel, lotion
Benzoyl peroxide 10%, gel, lotion
Cetirizine hydrochloride liquid 1 mg/ml
Cetirizine hydrochloride tablets 5 mg
Cetirizine hydrochloride tablets 10 mg
Chlorpheniramine maleate tablets 4 mg
Clotrimazole vaginal cream 1%
Diphenhydramine hydrochloride capsules 25 mg
Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml
Epinephrine racemic solution 2.25%
Ferrous sulfate solution 75 mg/0.6 ml (15 mg/0.6 ml elemental iron)
Ferrous sulfate tablets 325 mg
Ferrous sulfate elixir 220 mg/5 ml
Ferrous sulfate drops 75 mg/0.6 ml
Ferrous gluconate tablets 325 mg
Ferrous fumarate tablets 325 mg
Guaiifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid
Ibuprofen suspension 100 mg/5 ml
Ibuprofen tablets 200 mg
Insulin
Lactic acid (ammonium lactate) lotion 12%
Levonorgestrel 1.5 mg
Loperamide hydrochloride liquid 1 mg/5 ml
Loperamide hydrochloride liquid 1 mg/7.5 ml
Loperamide hydrochloride tablets 2 mg
Loratadine syrup 5 mg/5 ml

Loratadine tablets 10 mg
 Magnesium hydroxide suspension 400 mg/5 ml
 Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
 Miconazole nitrate cream 2% topical and vaginal
 Miconazole nitrate vaginal suppositories, 100 mg
 Mineral products with prior authorization
 Neomycin-bacitracin-polymyxin ointment
 Nicotine gum 2 mg, 4 mg
 Nicotine lozenge 2 mg, 4 mg
 Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
 Pediatric oral electrolyte solutions
 Permethrin lotion 1%
 Polyethylene glycol 3350 powder
 Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
 Pseudoephedrine hydrochloride liquid 30 mg/5 ml
 Pyrethrins-piperonyl butoxide liquid 0.33-4%
 Pyrethrins-piperonyl butoxide shampoo 0.3-3%
 Pyrethrins-piperonyl butoxide shampoo 0.33-4%
 Salicylic acid liquid 17%
 Senna tablets 187 mg
 Sennosides-docusate sodium tablets 8.6 mg-50 mg
 Sennosides syrup 8.8 mg/5 ml
 Sennosides tablets 8.6 mg
 Sodium bicarbonate tablets 325 mg
 Sodium bicarbonate tablets 650 mg
 Sodium chloride hypertonic ophthalmic ointment 5%
 Sodium chloride hypertonic ophthalmic solution 5%
 Tolnaftate 1% cream, solution, powder
 Vitamins, single and multiple with prior authorization
 Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

b. Nonprescription drugs for use in a nursing facility, PMIC, or ICF/ID shall be included in the per diem rate paid to the nursing facility, PMIC, or ICF/ID.

78.2(6) *Quantity prescribed.*

a. *Quantity prescribed.* When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe not less than a one-month supply of covered prescription and nonprescription medication. Contraceptives may be prescribed in three-month quantities.

b. *Prescription refills.*

(1) Prescription refills shall be performed and recorded in a manner consistent with existent state and federal laws, rules and regulations.

(2) Automatic refills.

1. Automatic refills are allowed. Participation in an automatic refill program is voluntary and opt-in only, on a drug-by-drug basis.

2. The program must have:

- Easy-to-locate contact information through telephone, the program's website, or both;
- Easy-to-understand patient materials on how to select or unselect drug(s) for inclusion and how to disenroll;
- Confirmation that the member wants to continue in the automatic refill program at least annually;
- Confirmation of continued medical necessity provided by the Medicaid member or person acting as an authorized representative of the member, before the member receives the medication at the

pharmacy or before the medication is mailed or delivered to the member, without which confirmation the drug(s) must be credited back to the Medicaid program; and

- Records of all consents, which must be in electronic or written format and must be available for review by auditors.

78.2(7) *Lowest cost item.* The pharmacist shall dispense the lowest cost item in stock that meets the requirements of the practitioner as shown on the prescription.

78.2(8) *Consultation.* In accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990), a pharmacist shall offer to discuss information regarding the use of the medication with each Medicaid member or the caregiver of a member presenting a prescription. The consultation is not required if the person refuses the consultation. Standards for the content of the consultation shall be found in rules of the Iowa board of pharmacy.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 8097B, IAB 9/9/09, effective 11/1/09; ARC 9175B, IAB 11/3/10, effective 1/1/11; ARC 9699B, IAB 9/7/11, effective 9/1/11; ARC 9834B, IAB 11/2/11, effective 11/1/11; ARC 9882B, IAB 11/30/11, effective 1/4/12; ARC 9981B, IAB 2/8/12, effective 3/14/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2930C, IAB 2/1/17, effective 4/1/17; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5175C, IAB 9/9/20, effective 6/1/21; ARC 5364C, IAB 12/30/20, effective 3/1/21]

441—78.3(249A) Inpatient hospital services. Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by the Iowa Medicaid enterprise. All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. (Cross reference 78.28(6)) The criteria are available from the IME Medical Services Unit, 100 Army Post Road, Des Moines, Iowa 50315, or in local hospital utilization review offices. No payment will be made for waiver days.

See rule 441—78.31(249A) for policies regarding payment of hospital outpatient services.

If the recipient is eligible for inpatient or outpatient hospital care through the Medicare program, payment will be made for deductibles and coinsurance as set out in 441—subrule 79.1(22).

The DRG payment calculations include any special services required by the hospital, including a private room.

78.3(1) Payment for Medicaid-certified physical rehabilitation units will be approved for the day of admission but not the day of discharge or death.

78.3(2) No payment will be approved for private duty nursing.

78.3(3) Certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance records are sufficient for the original certification.

78.3(4) Services provided for intestinal or gastric bypass surgery for treatment of obesity requires prior approval, which must be obtained by the attending physician before surgery is performed.

78.3(5) Payment will be approved for drugs provided inpatients subject to the same provisions specified in 78.2(1) and 78.2(4)“b”(1) to (10) except for 78.2(4)“b”(7). The basis of payment for drugs administered to inpatients is through the DRG reimbursement.

a. Payment will be approved for drugs and supplies provided outpatients subject to the same provisions specified in 78.2(1) through 78.2(4) except for 78.2(4)“b”(7). The basis of payment for drugs provided outpatients is through a combination of Medicaid-determined fee schedules and ambulatory payment classification, pursuant to 441—subrule 79.1(16).

b. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.3(6) Payment for nursing care provided by a hospital shall be made to those hospitals which have been certified by the department of inspections and appeals as meeting the standards for a nursing facility.

78.3(7) Payment for inpatient hospital tests for purposes of diagnosis and treatment shall be made only when the tests are specifically ordered for the diagnosis and treatment of a particular patient's condition by the attending physician or other licensed practitioner acting within the scope of practice as defined by law, who is responsible for that patient's diagnosis or treatment.

78.3(8) Rescinded IAB 2/6/91, effective 4/1/91.

78.3(9) Payment will be made for sterilizations in accordance with 78.1(16).

78.3(10) Payment will be approved for organ and tissue transplant services, as specified in subrule 78.1(20). Kidney, cornea, skin, bone, allogeneic bone marrow, autologous bone marrow, heart, liver, and lung transplants are covered as specified in subrule 78.1(20). Lung transplants are payable at Medicare-designated lung transplant centers only. Heart and liver transplants are payable when performed at facilities that meet the following criteria:

a. Recipient selection and education.

(1) *Selection.* The transplant center must have written criteria based on medical need for transplantation for final facility selection of recipients. These criteria should include an equitable, consistent and practical protocol for selection of recipients. The criteria must be at least as strict as those specified by Medicare.

(2) *Education.* The transplant center will provide a written plan for recipient education. It shall include educational plans for recipient, family and significant others during all phases of the program. These phases shall include:

Intake.

Preparation and waiting period.

Preadmission.

Hospitalization.

Discharge planning.

Follow-up.

b. Staffing and resource commitment.

(1) *Transplant surgeon.* The transplant center must have on staff a qualified transplant surgeon.

The surgeon must have received at least one year of training at a transplant center approved by the American Society of Transplant Surgeons under the direction of an experienced transplant surgeon and must have had at least two years of experience in all facets of transplant surgery specific to the surgeon's specialty. This experience must include management of recipients' presurgical and postsurgical care and actual experience as a member of a transplant team at the institution. The transplant surgeon will have an understanding of the principles of and demonstrated expertise in the use of immunosuppressive therapy.

The transplant surgeon will be certified by the American Board of Thoracic Surgery or equivalent for heart transplants and the American Board of Surgery or equivalent for liver transplants.

The transplant surgeon will be the defined leader of a stable, established transplant team that has a strong commitment to the transplant program.

(2) *Transplant team.* The transplant team will be clearly defined with leadership and corresponding responsibilities of all team members identified.

The team should consist of:

A surgeon director.

A board-certified internist or pediatrician with training and expertise in organ transplantation medicine and clinical use of immunosuppressive regimens.

The transplant center will assume responsibility for initial training and continuing education of the transplant team and ancillary personnel. The center will maintain records that demonstrate competency in achieving, maintaining and improving skills in the distinct areas of expertise of each of the team members.

(3) *Physicians.* The transplant center will have on staff or available for consultation physicians with the following areas of expertise:

Anesthesiology.

Cardiology.

Dialysis.

Gastroenterology.
Hepatology.
Immunology.
Infectious diseases.
Nephrology.
Neurology.
Pathology.
Pediatrics.
Psychiatry.
Pulmonary medicine.
Radiology.
Rehabilitation medicine.

Liaison with the recipient's permanent physician is established for the purpose of providing continuity and management of the recipient's long-term care.

(4) *Support personnel and resources.* The center must have a commitment of sufficient resources and planning for implementation and operation of the transplant program. Indicators of the commitment will include the following:

Persons with expertise in the following areas available at the transplant center:

Anesthesiology.
Blood bank services.
Cardiology.
Cardiovascular surgery.
Dialysis.
Dietary services.
Gastroenterology.
Infection control.

Laboratory services (pathology, microbiology, immunology, tissue typing, and monitoring of immunosuppressive drugs).

Legal counsel familiar with transplantation laws and regulations.

Nursing service department with staff available who have expertise in the care of transplant recipients, especially in managing immunosuppressed patients and hemodynamic support.

Respiratory therapy.
Pharmaceutical services.
Physical therapy.
Psychiatry.
Psycho-social.

The center will have active cardiovascular, medical, and surgical programs with the ability and willingness to perform diagnostic and evaluative procedures appropriate to transplants on an emergency and ongoing basis.

The center will have designated an adequate number of intensive care and general service beds to support the transplant center.

(5) *Laboratory.* Each transplant center must have direct local 24-hour per day access to histocompatibility testing facilities. These facilities must meet the Standards for Histocompatibility Testing set forth by the Committee on Quality Assurance and Standards of the American Society for Histocompatibility and Immunogenetics (ASHI). As specified by ASHI, the director of the facility shall hold a doctoral degree in biological science, or be a physician, and subsequent to graduation shall have had four years' experience in immunology, two of which were devoted to formal training in human histocompatibility testing, documented to be professionally competent by external measures such as national proficiency testing, participation in national or international workshops or publications in peer-reviewed journals. The laboratory must successfully participate in a regional or national testing program.

c. *Experience and survival rates.*

(1) *Experience.* Centers will be given a minimum volume requirement of 12 heart or 12 liver transplants that should be met within one year. Due to special considerations such as patient case mix or donor availability, an additional one year conditional approval may be given if the minimum volume is not met the first year.

For approval of an extrarenal organ transplant program it is highly desirable that the institution: 1. has available a complete team of surgeons, physicians, and other specialists with specific experience in transplantation of that organ, or 2. has an established approved renal transplant program at that institution and personnel with expertise in the extrarenal organ system itself.

(2) *Survival rates.* The transplant center will achieve a record of acceptable performance consistent with the performance and outcomes at other successful designated transplant centers. The center will collect and maintain recipient and graft survival and complication rates. A level of satisfactory success and safety will be demonstrated with bases for substantial probability of continued performance at an acceptable level.

To encourage a high level of performance, transplant programs must achieve and maintain a minimum one-year patient survival rate of 70 percent for heart transplants and 50 percent for liver transplants.

d. Organ procurement. The transplant center will participate in a nationwide organ procurement and typing network.

Detailed plans must exist for organ procurement yielding viable transplantable organs in reasonable numbers, meeting established legal and ethical criteria.

The transplant center must be a member of the National Organ Procurement and Transplant Network.

e. Maintenance of data, research, review and evaluation.

(1) *Maintenance of data.* The transplant center will collect and maintain data on the following:

Risk and benefit.

Morbidity and mortality.

Long-term survival.

Quality of life.

Recipient demographic information.

These data should be maintained in the computer at the transplant center monthly.

The transplant center will submit the above data to the United Network of Organ Sharing yearly.

(2) *Research.* The transplant center will have a plan for and a commitment to research.

Ongoing research regarding the transplanted organs is required.

The transplant center will have a program in graduate medical education or have a formal agreement with a teaching institution for affiliation with a graduate medical education program.

(3) *Review and evaluation.* The transplant center will have a plan for ongoing evaluation of the transplantation program.

The transplant center will have a detailed plan for review and evaluation of recipient selection, preoperative, operative, postoperative and long-term management of the recipient.

The transplant center will conduct concurrent ongoing studies to ensure high quality services are provided in the transplantation program.

The transplant center will provide information to members of the transplant team and ancillary staff regarding the findings of the quality assurance studies. This information will be utilized to provide education geared toward interventions to improve staff performance and reduce complications occurring in the transplant process.

The transplant center will maintain records of all quality assurance and peer review activities concerning the transplantation program to document identification of problems or potential problems, intervention, education and follow-up.

f. Application procedure. A Medicare-designated heart, liver, or lung transplant facility needs only to submit evidence of this designation to the Iowa Medicaid enterprise provider services unit. The application procedure for other heart and liver facilities is as follows:

(1) An original and two copies of the application must be submitted on 8½ by 11 inch paper, signed by a person authorized to do so. The facility must be a participating hospital under Medicaid and must

specify its provider number, and the name and telephone number of a contact person should there be questions regarding the application.

(2) Information and data must be clearly stated, well organized and appropriately indexed to aid in its review against the criteria specified in this rule. Each page must be numbered.

(3) To the extent possible, the application should be organized into five sections corresponding to each of the five major criteria and addressing, in order, each of the subcriteria identified.

(4) The application should be mailed to the Iowa Medicaid enterprise provider services unit.

g. Review and approval of facilities. An organized review committee will be established to evaluate performance and survival statistics and make recommendations regarding approval as a designated transplant center based on acceptable performance standards established by the review organization and approved by the Medicaid agency.

There will be established protocol for the systematic evaluation of patient outcome including survival statistics.

Once a facility applies for approval and is approved as a heart or liver transplant facility for Medicaid purposes, it is obliged to report immediately to the department any events or changes which would affect its approved status. Specifically, a facility must report any significant decrease in its experience level or survival rates, the transplantation of patients who do not meet its patient selection criteria, the loss of key members of the transplant team, or any other major changes that could affect the performance of heart or liver transplants at the facility. Changes from the terms of approval may lead to withdrawal of approval for Medicaid coverage of heart or liver transplants performed at the facility.

78.3(11) Payment will be approved for inpatient hospital care rendered a patient in connection with dental treatment only when the mental, physical, or emotional condition of the patient prevents the dentist from providing this necessary care in the office.

78.3(12) Payment will be approved for an assessment fee as specified in 441—paragraphs 79.1(16) “a” and “r” to determine if a medical emergency exists.

Medical emergency is defined as a sudden or unforeseen occurrence or combination of circumstances presenting a substantial risk to an individual’s health unless immediate medical treatment is given.

The determination of whether a medical emergency exists will be based on the patient’s medical condition including presenting symptoms and medical history prior to treatment or evaluation.

78.3(13) Payment for patients in acute hospital beds who are determined by the IME medical services unit to require the skilled nursing care level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3) plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by the IME medical services unit that the lower level of care is required or (b) for the days the IME medical services unit determines in an outlier review that the lower level of care was required.

78.3(14) Payment for patients in acute hospital beds who are determined by the IME medical services unit to require nursing facility level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(1) plus the non-direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(1), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by the IME medical services unit that the lower level of care is required or (b) for the days the IME medical services unit determines in an outlier review that the lower level of care was required.

78.3(15) Payment for inpatient hospital charges associated with surgical procedures normally done and billed on an outpatient hospital basis is subject to review by the IME medical services acute retrospective review team. Such reviews are based on random claim samples that are pulled on a monthly basis. If the information on a given inpatient claim included in that sample does not appear to support the appropriateness of inpatient level of care, that claim is sent to the IME medical director for further review. If the medical director approves the inpatient level of care, the claim is paid. However, if the medical director determines that the care provided could have been rendered at a lower level

of care, the hospital and attending physician are notified accordingly. If the hospital agrees with the finding that a lower level of care was appropriate, the hospital submits a new claim for the lower level of care. If the hospital disagrees with the lower level of care finding, the hospital can submit additional documentation for further review. The hospital or attending physician or both may appeal any final determination by the IME.

78.3(16) Skilled nursing care in “swing beds.”

a. Payment will be made for medically necessary skilled nursing care when provided by a hospital participating in the swing-bed program certified by the department of inspections and appeals and approved by the U.S. Department of Health and Human Services. Payment shall be at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3) and the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. Swing-bed placement is only intended to be short-term in nature.

b. Any payment for skilled nursing care provided in a hospital with a certified swing-bed program, for either initial admission or continued stay, will require prior authorization, subject to the following requirements:

- (1) The hospital has fewer than 100 beds, excluding beds for newborns and intensive care.
- (2) The hospital has an existing certification for a swing-bed program, pursuant to paragraph 78.3(16) “a.”
- (3) The member is being admitted for nursing facility or skilled level of care (if the member has Medicare and skilled coverage has been exhausted).
- (4) As part of the discharge planning process for a member requiring ongoing skilled nursing care, the hospital must:
 1. Complete a level of care (LOC) determination describing a member’s LOC needs, using Form 470-5156, Swing Bed Certification.
 2. Contact skilled nursing facilities within a 30-mile radius of the hospital regarding available beds to meet the member’s LOC needs.
 3. Certify that no freestanding skilled nursing facility beds are available for the member within a 30-mile radius of the hospital, which will be able to appropriately meet the member’s needs and that home-based care for the member is not available or appropriate.
- (5) Swing-bed stays beyond 14 days will only be approved when there is no appropriate freestanding nursing facility bed available within a 30-mile radius and home-based care for the member is not available or appropriate, as documented by the hospital seeking the swing-bed admission. For the purpose of these criteria, an “appropriate” nursing facility bed is a bed in a Medicaid-participating freestanding nursing facility that provides the LOC required for the member’s medical condition and corresponding LOC needs.
- (6) A Medicaid member who has been in a swing bed beyond 14 days must be discharged to an appropriate nursing facility bed within a 30-mile radius of the swing-bed hospital or to appropriate home-based care within 72 hours of an appropriate nursing facility bed becoming available.

Preadmission screening and resident review (PASRR) rules still apply for members being transferred to a nursing facility.

78.3(17) Rescinded IAB 8/9/89, effective 10/1/89.

78.3(18) Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Preprocedure review is also required for other types of major surgical procedures, such as organ transplants. Criteria are available from the IME medical services unit. (Cross reference 78.28(6))

78.3(19) Rescinded IAB 10/8/97, effective 12/1/97.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 0194C, IAB 7/11/12, effective 7/1/12; ARC 0354C, IAB 10/3/12, effective 12/1/12; ARC 0844C, IAB 7/24/13, effective 7/1/13; ARC 1054C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.4(249A) Dentists. Payment will be made for medical and surgical services furnished by a dentist to the extent these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy. Services must be reasonable, necessary, and cost-effective for the prevention, diagnosis, and treatment of dental disease or injuries or for oral devices necessary for a medical condition. Payment will also be made for the following dental procedures:

78.4(1) Preventive services. Payment shall be made for the following preventive services:

a. Oral prophylaxis, including necessary scaling and polishing, is payable only once in a six-month period except for persons who, because of a physical or mental condition, need more frequent care. Documentation supporting the need for oral prophylaxis performed more than once in a six-month period must be maintained.

b. Topical application of fluoride is payable once every 90 days. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

c. Pit and fissure sealants are payable for placement on deciduous and permanent posterior teeth only. Reimbursement for sealants is restricted to work performed on members through 18 years of age and on members who have a physical or mental condition that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

d. Space management services are payable in mixed dentition when premature loss of teeth would permit existing teeth to shift and cause a handicapping malocclusion or there is too little dental ridge to accommodate either the number or the size of teeth and significant dental disease will result if the condition is not corrected.

78.4(2) Diagnostic services. Payment shall be made for the following diagnostic services:

a. A comprehensive oral evaluation is payable once per member per dental practice in a three-year period when the member has not been seen by a dentist in the dental practice during the three-year period.

b. A periodic oral examination is payable once in a six-month period.

c. A full mouth radiograph survey, consisting of a minimum of 14 periapical films and bite-wing films, or a panoramic radiograph with bite-wings is a payable service once in a five-year period, except when medically necessary to evaluate development and to detect anomalies, injuries and diseases. Full mouth radiograph surveys are not payable under the age of six except when medically necessary. A panoramic-type radiography with bite-wings is considered the same as a full mouth radiograph survey.

d. Supplemental bitewing films are payable only once in a 12-month period.

e. Single periapical films are payable when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

h. Posterior-anterior and lateral skull and facial bone radiograph, survey film.

i. Temporomandibular joint radiograph.

j. Cephalometric film.

k. Diagnostic casts are payable only for orthodontic cases or dental implants or when requested by the Iowa Medicaid enterprise medical services unit's dental consultant.

l. Cone beam images are payable when medically necessary for situations including, but not limited to, detection of tumors, positioning of severely impacted teeth, supernumerary teeth or dental implants.

78.4(3) Restorative services. Payment shall be made for the following restorative services:

a. Treatment of dental caries is payable in those areas which require immediate attention. Restoration of incipient or nonactive carious lesions are not payable. Carious activity may be considered incipient when there is no penetration of the dento-enamel junction as demonstrated in diagnostic radiographs.

b. Amalgam alloy and composite resin-type filling materials are reimbursable only once for the same restoration in a two-year period.

c. Rescinded IAB 5/1/02, effective 7/1/02.

d. Crowns are payable when there is at least a fair prognosis for maintaining the tooth as determined by the Iowa Medicaid enterprise medical services unit and a more conservative procedure would not be serviceable.

(1) Stainless steel crowns are limited to primary and permanent posterior teeth and are covered when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration. Placement on permanent posterior teeth is allowed only for members who have a mental or physical condition that limits their ability to tolerate the procedure for placement of a different crown.

(2) Aesthetic coated stainless steel crowns and stainless steel crowns with a resin window are limited to primary anterior teeth.

(3) Laboratory-fabricated crowns, other than stainless steel, are limited to permanent teeth and require prior authorization. Approval shall be granted when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration or there is evidence of recurring decay surrounding a large existing restoration, a fracture, a broken cusp(s), or an endodontic treatment.

(4) Crowns with noble or high noble metals require prior authorization. Approval shall be granted for members who meet the criteria for a laboratory-fabricated crown, other than stainless steel, and who have a documented allergy to all other restorative materials.

e. Cast post and core, post and composite or post and amalgam in addition to a crown are payable when a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

f. Payment as indicated will be made for the following restoration procedures:

(1) Amalgam or acrylic buildups, including any pins, are considered a core buildup.

(2) One, two, or more restorations on one surface of a tooth shall be paid as a one-surface restoration, i.e., mesial occlusal pit and distal occlusal pit of a maxillary molar or mesial and distal occlusal pits of a lower bicuspid.

(3) Occlusal lingual groove of a maxillary molar that extends from the distal occlusal pit and down the distolingual groove will be paid as a two-surface restoration. This restoration and a mesial occlusal pit restoration on the same tooth will be paid as one, two-surface restoration.

(4) Rescinded IAB 5/1/02, effective 7/1/02.

(5) Two separate one-surface restorations are payable as a two-surface restoration (i.e., an occlusal pit restoration and a buccal pit restoration are a two-surface restoration).

(6) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, and local anesthesia are included in the restorative fee and may not be billed separately.

(7) Pin retention will be paid on a per-tooth basis and in addition to the final restoration.

(8) More than four surfaces on an amalgam restoration will be reimbursed as a "four-surface" amalgam.

(9) An amalgam or composite restoration is not payable following a sedative filling in the same tooth unless the sedative filling was placed more than 30 days previously.

78.4(4) Periodontal services. Payment may be made for the following periodontal services:

a. Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis is payable once every 24 months. This procedure is not payable on the same date of service when other prophylaxis or periodontal services are performed.

b. Periodontal scaling and root planing is payable once every 24 months when prior approval has been received. Prior approval shall be granted per quadrant when radiographs demonstrate subgingival calculus or loss of crestal bone and when the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross reference 78.28(3) "a"(1))

c. Periodontal surgical procedures which include gingivoplasty, osseous surgery, and osseous allograft are payable services when prior approval has been received. Payment for these surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the member has demonstrated reasonable oral hygiene. Payment is also allowed for members who are unable to demonstrate reasonable oral hygiene due to a physical or mental condition, or who exhibit evidence of gingival hyperplasia, or who have a deep carious lesion that cannot be otherwise accessed for restoration.

d. Tissue grafts. Pedicle soft tissue graft, free soft tissue graft, and subepithelial connective tissue graft are payable services with prior approval. Authorization shall be granted when the amount of tissue loss is causing problems such as continued bone loss, chronic root sensitivity, complete loss of attached tissue, or difficulty maintaining adequate oral hygiene. (Cross reference 78.28(3) "a"(2))

e. Periodontal maintenance therapy requires prior authorization. Approval shall be granted for members who have completed periodontal scaling and root planing at least three months prior to the initial periodontal maintenance therapy and the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross reference 78.28(3) "a"(3))

f. Tissue regeneration procedures require prior authorization. Approval shall be granted when radiographs show evidence of recession in relation to the muco-gingival junction and the bone level indicates the tooth has a fair to good long-term prognosis.

g. Localized delivery of antimicrobial agents requires prior authorization. Approval shall be granted when at least one year has elapsed since periodontal scaling and root planing was completed, the member has maintained regular periodontal maintenance, and pocket depths remain at a moderate to severe depth with bleeding on probing. Authorization is limited to once per site every 12 months.

78.4(5) Endodontic services. Payment shall be made for the following endodontic services:

a. Root canal treatments on permanent anterior and posterior teeth when there is presence of extensive decay, infection, draining fistulas, severe pain upon chewing or applied pressure, prolonged sensitivity to temperatures, or a discolored tooth indicative of a nonvital tooth.

b. Vital pulpotomies. Cement bases, pulp capping, and insulating liners are considered part of the restoration and may not be billed separately.

c. Surgical endodontic treatment, including an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue is payable when nonsurgical treatment has been attempted and a reasonable time of approximately one year has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

(1) Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross reference 78.28(3) "c")

d. Endodontic retreatment when prior authorization has been received. Authorization for retreatment of a tooth with previous endodontic treatment shall be granted when the conventional treatment has been completed, a reasonable time has elapsed since the initial treatment, and failure has been demonstrated with a radiograph and narrative history. A reasonable period of time is approximately one year if the treating dentist is the same and may be less if the member must see a different dentist.

78.4(6) Oral surgery—medically necessary. Payment shall be made for medically necessary oral surgery services furnished by dentists to the extent that these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy, as defined in rule 441—78.1(249A). These services will be reimbursed in a manner consistent with the physician's reimbursement policy. The following surgical procedures are also payable when performed by a dentist:

a. Extractions, both surgical and nonsurgical.

b. Impaction (soft tissue impaction, upper or lower) that requires an incision of overlying soft tissue and the removal of the tooth.

c. Impaction (partial bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth.

d. Impaction (complete bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and section of the tooth for removal.

e. Root recovery (surgical removal of residual root).

f. Oral antral fistula closure (or antral root recovery).

g. Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including ligation when indicated.

h. Surgical exposure of impacted or unerupted tooth to aid eruption.

i. Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.

j. Payment may be made for postoperative care where need is shown to be beyond normal follow-up care or for postoperative care where the original service was performed by another dentist.

78.4(7) Prosthetic services. Payment may be made for the following prosthetic services:

a. An immediate denture or a first-time complete denture. Six months' postdelivery care is included in the reimbursement for the denture.

b. A removable partial denture replacing anterior teeth when prior approval has been received. Approval shall be granted when radiographs demonstrate adequate space for replacement of a missing anterior tooth. Six months' postdelivery care is included in the reimbursement for the denture.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. Approval shall be granted when the member has fewer than eight posterior teeth in occlusion, excluding third molars, or the member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. Six months' postdelivery care is included in the reimbursement for the denture. (Cross reference 78.28(3) "b"(1))

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. Approval shall be granted for members who:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have an existing bridge that needs replacement due to breakage or extensive, recurrent decay.

High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. (Cross reference 78.28(3) "b"(2))

e. A fixed partial denture replacing posterior teeth when prior approval has been received. Approval shall be granted for members who meet the criteria for a removable partial denture and:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have a full denture in one arch and a partial fixed denture replacing posterior teeth is required in the opposing arch to balance occlusion.

High noble or noble metals will be approved only when the member is allergic to all other restorative materials.

f. Obturator for surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

g. Chairside relines and laboratory-processed relines are payable only once per prosthesis every 12 months, beginning 6 months after placement of the denture.

h. Tissue conditioning is a payable service twice per prosthesis in a 12-month period.

i. Two repairs per prosthesis in a 12-month period are payable.

j. Adjustments to a complete or removable partial denture are payable when medically necessary after six months' postdelivery care. An adjustment consists of removal of acrylic material or adjustment of teeth to eliminate a sore area or to make the denture fit better. Warming dentures and massaging them for better fit or placing them in a sonic device does not constitute an adjustment.

k. Dental implants and related services when prior authorization has been received. Prior authorization shall be granted when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

l. Replacement of complete or partial dentures in less than a five-year period requires prior authorization. Approval shall be granted once per denture replacement per arch in a five-year period when the denture has been lost, stolen or broken beyond repair or cannot be adjusted for an adequate fit. Approval shall also be granted for more than one denture replacement per arch within five years for members who have a medical condition that necessitates thorough mastication. Approval will not be granted in less than a five-year period when the reason for replacement is resorption.

m. A complete or partial denture rebase requires prior approval. Approval shall be granted when the acrylic of the denture is cracked or has had numerous repairs and the teeth are in good condition.

n. An oral appliance for obstructive sleep apnea requires prior approval and must be custom-fabricated. Approval shall be granted in accordance with Medicare criteria.

78.4(8) Orthodontic procedures. Payment may be made for the following orthodontic procedures:

a. Minor treatment to control harmful habits when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required. (Cross reference 78.28(3) “c”)

b. Interceptive orthodontic treatment of the transitional dentition when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.

c. Comprehensive orthodontic treatment when prior approval has been received. Approval is limited to members under 21 years of age and shall be granted when the member has a severe handicapping malocclusion with a score of 26 or above using the index from the “Handicapping Malocclusion Assessment to Establish Treatment Priority,” by J.A. Salzman, D.D.S., American Journal of Orthodontics, October 1968.

78.4(9) Adjunctive general services. Payment may be made for the following:

a. Treatment in a hospital. Payment will be approved for dental treatment rendered to a hospitalized member only when the mental, physical, or emotional condition of the member prevents the dentist from providing necessary care in the office.

b. Treatment in a nursing facility. Payment will be approved for dental treatment provided in a nursing facility. When more than one patient is examined during the same nursing home visit, payment will be made by the Medicaid program for only one visit to the nursing home.

c. Office visit. Payment will be approved for an office visit for care of injuries or abnormal conditions of the teeth or supporting structure when treatment procedures or examinations are not billed for that visit.

d. Office calls after hours. Payment will be approved for office calls after office hours in emergency situations. The office call will be paid in addition to treatment procedures.

e. Drugs. Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist’s office is located. If eligible to dispense drugs, the dentist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for the writing of prescriptions.

f. Anesthesia. General anesthesia, intravenous sedation, and nonintravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants use of anesthesia. Inhalation of nitrous oxide is payable when the age or physical or mental condition of the member necessitates the use of minimal sedation for dental procedures.

g. Occlusal guard. A removable dental appliance to minimize the effects of bruxism and other occlusal factors requires prior approval. Approval shall be granted when the documentation supports evidence of significant loss of tooth enamel, tooth chipping, headaches or jaw pain.

78.4(10) Orthodontic services to members 21 years of age or older. Orthodontic procedures are not covered for members 21 years of age or older.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0631C, IAB 3/6/13, effective 5/1/13; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.5(249A) Podiatrists. Payment will be approved only for certain podiatric services.

78.5(1) Payment will be approved for the following orthotic appliances and treatment of nail pathologies:

- a.* Durable plantar foot orthotic.
- b.* Plaster impressions for foot orthotic.
- c.* Molded digital orthotic.

- d. Shoe padding when appliances are not practical.
- e. Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.
- f. Rams horn (hypertrophic) nails.
- g. Onychomycosis (mycotic) nails.

78.5(2) Payment will be made for the same scope of podiatric services available through Part B of Title XVIII (Medicare) except as listed below:

a. Treatment of flatfoot. The term “flatfoot” is defined as a condition in which one or more arches have flattened out.

b. Treatment of subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

c. Routine foot care. Routine foot care includes the cutting or removal of corns or callouses, the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

d. Orthopedic shoes. Payment will not be made for orthopedic shoes or for any device to be worn in or attached to orthopedic shoes or other types of shoes when provided by the podiatrist. Payment will be made to the podiatrist for the examination including tests to establish the need for orthopedic shoes.

78.5(3) Prescriptions are required for drugs and supplies as specified in paragraph 78.1(2)“c.” Payment shall be made for drugs dispensed by a podiatrist only if there is no licensed retail pharmacy in the community where the podiatrist’s office is located. If eligible to dispense drugs, the podiatrist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for writing prescriptions.

This rule is intended to implement Iowa Code section 249A.4.

441—78.6(249A) Optometrists. Payment will be approved for medically necessary services and supplies provided by the optometrist within the scope of practice of optometry and the limitations of state law, subject to the following limitations and exclusions. Covered optometric services include a professional component and materials.

78.6(1) Payable professional services. Payable professional services are:

a. Eye examinations. The coverage of eye examinations depends on the purpose of the examination. Services are covered if the examination is the result of a complaint or symptom of an eye disease or injury. Routine eye examinations are covered once in a 12-month period. These services are rendered in the optometrist’s office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B. The following levels of service are recognized for optometric examinations:

(1) Intermediate examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program.

(2) Comprehensive examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program, and a general evaluation of the complete visual system.

b. Medical services. Payment will be approved for medically necessary services and supplies within the scope of practice of the optometrist, including services rendered in the optometrist’s office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B.

c. Auxiliary procedures. The following auxiliary procedures and special tests are payable when performed by an optometrist. Auxiliary procedures and special tests are reimbursed as a separate procedure only when warranted by case history or diagnosis.

(1) Serial tonometry. Single tonometry is part of the intermediate and comprehensive exams and is not payable as a separate procedure as is serial tonometry.

(2) Gonioscopy.

(3) Extended ophthalmoscopy. Routine ophthalmoscopy is part of the intermediate and comprehensive examination and is not payable as a separate procedure. Generally, extended ophthalmoscopy is considered to be part of the comprehensive examination and, if performed in conjunction with that level of service, is not payable as a separate procedure.

(4) Visual fields. Gross visual field testing is part of general optometric services and is not reported separately.

(5) External photography.

(6) Fundus photography.

(7) Retinal integrity evaluation with a three-mirror lens.

d. Single vision and multifocal spectacle lens service, verification and subsequent service. When lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

(1) When spectacle lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

1. Ordering of corrective lenses.

2. Verification of lenses after fabrication.

3. Adjustment and alignment of completed lens order.

(2) New spectacle lenses are subject to the following limitations:

1. Up to three times for children up to one year of age.

2. Up to four times per year for children one through three years of age.

3. Once every 12 months for children four through seven years of age.

4. Once every 24 months after eight years of age when there is a change in the prescription.

(3) Spectacle lenses made from polycarbonate or equivalent material are allowed for:

1. Children through seven years of age.

2. Members with vision in only one eye.

3. Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

e. Rescinded IAB 4/3/02, effective 6/1/02.

f. Frame service.

(1) When a new frame is necessary, the following enumerated professional and technical optometric services are to be provided:

1. Selection and styling.

2. Sizing and measurements.

3. Fitting and adjustment.

4. Readjustment and servicing.

(2) New frames are subject to the following limitations:

1. One frame every six months is allowed for children through three years of age.

2. One frame every 12 months is allowed for children four through seven years of age.

3. When there is a covered lens change and the new lenses cannot be accommodated by the current frame.

(3) Safety frames are allowed for:

1. Children through seven years of age.

2. Members with a diagnosis-related disability or illness where regular frames would pose a safety risk or result in frequent breakage.

g. Rescinded IAB 4/3/02, effective 6/1/02.

h. Repairs or replacement of frames, lenses or component parts. Payment shall be made for service in addition to materials. The service fee shall not exceed the dispensing fee for a replacement frame. Payment shall be made for replacement of glasses when the original glasses have been lost or damaged beyond repair. Replacement of lost or damaged glasses is limited to one pair of frames and two lenses once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Contact lenses. Payment shall be made for documented keratoconus, aphakia, high myopia, anisometropia, trauma, severe ocular surface disease, irregular astigmatism, for treatment of acute or chronic eye disease, or when the member's vision cannot be adequately corrected with spectacle lenses. Contact lenses are subject to the following limitations:

- (1) Up to 16 gas permeable contact lenses are allowed for children up to one year of age.
- (2) Up to 8 gas permeable contact lenses are allowed every 12 months for children one through three years of age.
- (3) Up to 6 gas permeable contact lenses are allowed every 12 months for children four through seven years of age.
- (4) Two gas permeable contact lenses are allowed every 24 months for members eight years of age or older.
- (5) Soft contact lenses and replacements are allowed when medically necessary.

78.6(2) Ophthalmic materials. Ophthalmic materials which are provided in connection with any of the foregoing professional optometric services shall provide adequate vision as determined by the optometrist and meet the following standards:

- a.* Corrected curve lenses, unless clinically contraindicated.
- b.* Standard plastic, plastic and metal combination, or metal frames.
- c.* Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance.

78.6(3) Reimbursement. The reimbursement for allowed ophthalmic material is subject to a fee schedule established by the department or to actual laboratory cost as evidenced by an attached invoice. Reimbursement for rose tint is included in the fee for the lenses.

a. Materials payable by fee schedule are:

- (1) Spectacle lenses, single vision and multifocal.
- (2) Frames.
- (3) Case for glasses.

b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:

- (1) Contact lenses.
- (2) Schroeder shield.
- (3) Ptosis crutch.
- (4) Safety frames.
- (5) Subnormal visual aids.
- (6) Photochromatic lenses.

78.6(4) Prior authorization. Prior authorization is required for the following:

a. A second lens correction within a 24-month period for members eight years of age and older. Approval shall be given when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process shall be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is at or better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal visual aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles, or reverse Galilean telescope systems. Payment shall be actual laboratory cost as evidenced by an attached invoice.

d. Approval for photochromatic tint shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Approval for press-on prisms shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

(Cross reference 78.28(4))

78.6(5) *Noncovered services.* Noncovered services include, but are not limited to, the following services:

- a.* Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.
- b.* Glasses for occupational eye safety.
- c.* A second pair of glasses or spare glasses.
- d.* Cosmetic surgery and experimental medical and surgical procedures.
- e.* Sunglasses.
- f.* Progressive bifocal or trifocal lenses.

78.6(6) *Therapeutically certified optometrists.* Rescinded IAB 9/5/12, effective 11/1/12.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies shall be the same as described in rule 441—78.6(249A). (Cross reference 78.28(4))

78.7(1) to 78.7(3) Rescinded IAB 4/3/02, effective 6/1/02.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.8(249A) Chiropractors. Payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (Medicare).

78.8(1) *Covered services.* Chiropractic manipulative therapy (CMT) eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.

78.8(2) *Indications and limitations of coverage.*

a. The subluxation must have resulted in a neuromusculoskeletal condition set forth in the table below for which CMT is appropriate treatment. The symptoms must be directly related to the subluxation that has been diagnosed. The mere statement or diagnosis of “pain” is not sufficient to support the medical necessity of CMT. CMT must have a direct therapeutic relationship to the patient’s condition. No other diagnostic or therapeutic service furnished by a chiropractor is covered under the Medicaid program.

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
G44.1	Vascular headache NEC*	G54.0- G54.4	Nerve root and plexus disorders, brachial plexus disorders, lumbosacral plexus disorders, cervical root disorders NEC, thoracic root disorders NEC, lumbosacral root disorders NEC	M48.30- M48.33	Traumatic spondylopathy, site unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region
G44.209	Tension headache, unspecified, not intractable	G54.8	Other nerve root and plexus disorders	M48.35- M48.38	Traumatic spondylopathy, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region
M47.21- M47.28	Other spondylosis with radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G54.9	Nerve root and plexus disorder, unspecified	M50.20- M50.23	Other cervical disc displacement
M47.811- M47.818	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G55	Nerve root and plexus compressions in diseases classified elsewhere	M50.30- M50.33	Other cervical disc degeneration
M47.891- M47.898	Other spondylosis, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	M43.00- M43.28	Spondylolysis; spondylolisthesis; fusion of spine	M51.24- M51.27	Other thoracic, thoracolumbar and lumbosacral intervertebral disc displacement
M54.2	Cervicalgia	M43.6	Torticollis	M51.34- M51.37	Other thoracic, thoracolumbar and lumbosacral intervertebral disc degeneration
M54.5	Low back pain	M46.00- M46.09	Spinal enthesopathy	M54.30- M54.32	Sciatica
M54.6	Pain in the thoracic spine	M46.41- M46.47	Discitis, unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region	M54.40- M54.42	Lumbago with sciatica
M54.81	Occipital neuralgia	M48.00- M48.08	Spinal stenosis	M96.1	Postlaminectomy syndrome, NEC
M54.89	Other dorsalgia	M48.34	Traumatic spondylopathy, thoracic region		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
M54.9	Dorsalgia, unspecified	M50.10- M50.13	Cervical disc disorder with radiculopathy		
R51	Headache	M50.80- M50.83	Other cervical disc disorders		
		M50.90- M50.93	Cervical disc disorder, unspecified		
		M51.14- M51.17	Intervertebral disc disorders with radiculopathy, thoracic region, thoracolumbar region, lumbar region, lumbosacral region		
		M51.84- M51.87	Other thoracic, thoracolumbar and lumbosacral intervertebral disc disorders		
		M53.0	Cervicocranial syndrome		
		M53.1	Cervicobrachial syndrome		
		M53.2X1- M53.2X9	Spinal instabilities		
		M53.3	Sacrococcygeal disorders NEC		
		M53.80	Other specified dorsopathies, site unspecified		
		M53.84- M53.88	Other specified dorsopathies, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region		
		M53.9	Dorsopathy, unspecified		
		M54.10- M54.18	Radiculopathy		
		M60.80	Other myositis, unspecified site		
		M60.811, M60.812	Other myositis, shoulder, right, left		
		M60.819	Other myositis, unspecified shoulder		
		M60.821, M60.822	Other myositis, upper arm, right, left		
		M60.829	Other myositis, unspecified upper arm		
		M60.831, M60.832	Other myositis, forearm, right, left		
		M60.839	Other myositis, unspecified forearm		
		M60.841, M60.842	Other myositis, hand, right, left		
		M60.849	Other myositis, unspecified hand		
		M60.851, M60.852	Other myositis, thigh, right, left		
		M60.859	Other myositis, unspecified thigh		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		M60.861, M60.862	Other myositis, lower leg, right, left		
		M60.869	Other myositis, unspecified lower leg		
		M60.871, M60.872	Other myositis, ankle and foot, right, left		
		M60.879	Other myositis, unspecified ankle and foot		
		M60.88, M60.89	Other myositis, other site, multiple sites		
		M60.9	Myositis, unspecified		
		M62.830	Muscle spasm of back		
		M72.9	Fibroblastic disorder, unspecified		
		M79.1	Myalgia		
		M79.2	Neuralgia and neuritis, unspecified		
		M79.7	Fibromyalgia		
		M99.20- M99.23	Subluxation stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.30- M99.33	Osseous stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.40- M99.43	Connective tissue stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.50- M99.53	Intervertebral disc stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.60- M99.63	Osseous and subluxation stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		M99.70- M99.73	Connective tissue and disc stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		Q76.2	Congenital spondylolisthesis		
		S13.4XXA, S13.4XXD	Sprain of ligaments of cervical spine, initial encounter, subsequent encounter		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		S13.8XXA, S13.8XXD	Sprain of joints and ligaments of other parts of neck, initial encounter, subsequent encounter		
		S16.1XXA, S16.1XXD	Strain of muscle, fascia and tendon at neck level, initial encounter, subsequent encounter		
		S23.3XXA, S23.3XXD	Sprain of ligaments of thoracic spine, initial encounter, subsequent encounter		
		S23.8XXA, S23.8XXD	Sprain of other specified parts of thorax, initial encounter, subsequent encounter		
		S33.5XXA, S33.5XXD	Sprain of ligaments of lumbar spine, initial encounter, subsequent encounter		
		S33.6XXA, S33.6XXD	Sprain of sacroiliac joint, initial encounter, subsequent encounter		

* NEC means not elsewhere classified.

b. The neuromusculoskeletal conditions listed in the table in paragraph “*a*” generally require short-, moderate-, or long-term CMT. A diagnosis or combination of diagnoses within Category I generally requires short-term CMT of 12 per 12-month period. A diagnosis or combination of diagnoses within Category II generally requires moderate-term CMT of 18 per 12-month period. A diagnosis or combination of diagnoses within Category III generally requires long-term CMT of 24 per 12-month period. For diagnostic combinations between categories, 28 CMTs are generally required per 12-month period. If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.

c. CMT is not a covered benefit when:

- (1) The maximum therapeutic benefit has been achieved for a given condition.
- (2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient’s condition.
- (3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

78.8(3) Documenting X-ray. An X-ray must document the primary regions of subluxation being treated by CMT.

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment shall be made for subsequent X-rays, absent a new condition, consistent with paragraph “*c*” of this subrule. No X-ray is required for pregnant women and for children aged 18 and under.

b. The X-ray films shall be labeled with the patient’s name and date the X-rays were taken and shall be marked right or left. The X-ray shall be made available to the department or its duly authorized representative when requested. A written and dated X-ray report, including interpretation and diagnosis, shall be present in the patient’s clinical record.

c. Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which

major commercial payors reimburse chiropractors. The Iowa Medicaid enterprise shall publish in the Chiropractic Services Provider Manual the current list of payable X-ray CPT codes. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays shall be further limited to one per condition, consistent with the provisions of paragraph “a” of this subrule. A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph “a” of this subrule. A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor’s office. Any X-rays so ordered shall be payable to the X-ray provider, consistent with the provisions in this paragraph.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—78.9(249A) Home health agencies. Payment shall be approved for medically necessary home health agency services prescribed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant in a plan of home health care provided by a Medicare-certified home health agency.

The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

The member need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency shall only be covered when provided in the member’s residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at 78.9(10) “a” may be provided in settings other than the member’s residence when medically necessary.

Medicaid members of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) to 78.9(10).

Payment shall be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

Payment for supplies shall be approved when the supplies are incidental to the patient’s care, e.g., syringes for injections, and do not exceed \$15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the member’s community.

Payment may be made for restorative and maintenance home health agency services.

Payment may be made for teaching, training, and counseling in the provision of health care services.

Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

Services shall be authorized by a physician, nurse practitioner, clinical nurse specialist, or physician assistant, evidenced by the physician’s, nurse practitioner’s, clinical nurse specialist’s, or physician assistant’s signature and date on a plan of treatment.

78.9(1) Treatment plan. A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 60 days thereafter. There must be a face-to-face encounter between a physician, a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant and the Medicaid member no more than 90 days before or 30 days after the start of service. The

plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- a. Place of service.
- b. Type of service to be rendered and the treatment modalities being used.
- c. Frequency of the services.
- d. Assistance devices to be used.
- e. Date home health services were initiated.
- f. Progress of member in response to treatment.
- g. Medical supplies to be furnished.
- h. Member's medical condition as reflected by the following information, if applicable:
 - (1) Dates of prior hospitalization.
 - (2) Dates of prior surgery.
 - (3) Date last seen by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.
 - (4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
 - (5) Prognosis.
 - (6) Functional limitations.
 - (7) Vital signs reading.
 - (8) Date of last episode of instability.
 - (9) Date of last episode of acute recurrence of illness or symptoms.
 - (10) Medications.
- i. Discipline of the person providing the service.
- j. Certification period (no more than 60 days).
- k. Estimated date of discharge from the hospital or home health agency services, if applicable.
- l. Physician's, nurse practitioner's, clinical nurse specialist's, or physician assistant's signature and date. The plan of care must be signed and dated by the physician, nurse practitioner, clinical nurse specialist, or physician assistant before the claim for service is submitted for reimbursement.

78.9(2) Supervisory visits. Payment shall be made for supervisory visits two times a month when a registered nurse acting in a supervisory capacity provides supervisory visits of services provided by a home health aide under a home health agency plan of treatment or when services are provided by an in-home health care provider under the department's in-home health-related care program as set forth in 441—Chapter 177.

78.9(3) Skilled nursing services. Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services shall be defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end shall be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's, nurse practitioner's, clinical nurse specialist's, or physician assistant's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections shall be covered when ordered by a physician, nurse practitioner, clinical nurse specialist, or a physician assistant and included in the plan of care. Other daily skilled nursing visits which are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and shall be denied.

Skilled nursing services shall be evaluated based on the complexity of the service and the condition of the patient.

Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

78.9(4) *Physical therapy services.* Payment shall be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or physician assistant after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "b."

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(5) *Occupational therapy services.* Payment shall be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or physician assistant, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "c."

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(6) *Speech therapy services.* Payment shall be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or physician assistant, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "d."

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(7) *Home health aide services.* Payment shall be made for unskilled services provided by a home health aide if the following conditions are met:

a. The service as well as the frequency and duration are stated in a written plan of treatment established by a physician, nurse practitioner, clinical nurse specialist, or physician assistant. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

b. The member requires personal care services as determined by a registered nurse or other appropriate therapist. The services shall be given under the supervision of a registered nurse, physical, speech, or occupational therapist and the registered nurse or therapist shall assign the aide who will provide the care.

c. Services shall be provided on an intermittent basis. "Intermittent basis" for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant and included in a plan of care shall be allowed as intermittent services. Increased services provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

Personal care services include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or

housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the member, e.g., lives alone or with family.

78.9(8) *Medical social services.* Rescinded IAB 3/29/17, effective 5/3/17.

78.9(9) *Home health agency care for maternity patients and children.* The intent of home health agency services for maternity patients and children shall be to provide services when the members are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician's office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

a. Treatment plans for maternity patients and children shall identify:

- (1) The potential risk factors,
- (2) The medical factor or symptom which verifies the child is at risk,
- (3) The reason the member is unable to obtain care outside of the home,
- (4) The medically related task of the home health agency,
- (5) The member's diagnosis,
- (6) Specific services and goals, and
- (7) The medical necessity for the services to be rendered. A single high-risk factor does not provide sufficient documentation of the need for services.

b. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.
- (4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.
- (5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.
- (6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.
- (7) Second pregnancy in 12 months.
- (8) Death of a close family member or significant other within the previous year.

c. The following list of potential high-risk factors may indicate a need for home health services to postpartum maternity patients:

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.
- (4) Preexisting mental or physical disabilities such as deaf, blind, hemiplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or intellectual disability.
- (5) Drug or alcohol abuse.
- (6) Symptoms of postpartum psychosis.
- (7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.
- (8) Demonstrated disturbance in maternal and infant bonding.
- (9) Discharge or release from hospital against medical advice before 36 hours postpartum.
- (10) Insufficient antepartum care by history.
- (11) Multiple births.
- (12) Nonhospital delivery.

d. The following list of potential high-risk factors may indicate a need for home health services to infants:

- (1) Birth weight of five pounds or under or over ten pounds.

- (2) History of severe respiratory distress.
- (3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.
- (4) Disabling birth injuries.
- (5) Extended hospitalization and separation from other family members.
- (6) Genetic disorders, such as Down's syndrome, and phenylketonuria or other metabolic conditions that may lead to intellectual disability.
- (7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.
- (8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.
- (9) Discharge or release against medical advice before 36 hours of age.
- (10) Nutrition or feeding problems.

e. The following list of potential high-risk factors may indicate a need for home health services to preschool or school-age children:

- (1) Child or sibling victim of child abuse or neglect.
- (2) Intellectual disability or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.
- (3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.
- (4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.
- (5) Malignancies such as leukemia or carcinoma.
- (6) Severe injuries necessitating treatment or rehabilitation.
- (7) Disruption in family or peer relationships.
- (8) Suspected developmental delay.
- (9) Nutritional deficiencies.

78.9(10) *Private duty nursing or personal care services for persons aged 20 and under.* Payment for private duty nursing or personal care services for persons aged 20 and under shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member. Enhanced payment under the interim fee schedule shall be made available for services to children who are technology dependent, i.e., ventilator dependent or whose medical condition is so unstable as to otherwise require intensive care in a hospital.

Private duty nursing or personal care services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.
5. Transportation services.

6. Homework assistance.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.28(10))

78.9(11) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a home health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 9315B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 3005C, IAB 3/29/17, effective 5/3/17; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5487C, IAB 3/10/21, effective 4/14/21]

441—78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies.

78.10(1) General payment requirements. Payment will be made for items of DME, prosthetic devices and medical supplies, subject to the following general requirements and the requirements of subrule 78.10(2), 78.10(3), or 78.10(4), as applicable:

a. DME, prosthetic devices, and medical supplies must be required by the member because of the member's medical condition.

b. The item shall be necessary and reasonable either for the treatment of an illness or injury, or to improve the functioning of a malformed body part. Determination will be made by the Iowa Medicaid enterprise medical services unit.

(1) An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part.

(2) Although an item may be necessary, it must also be a reasonable expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness: Whether the expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item; whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and whether the item serves essentially the same purpose as an item already available to the beneficiary.

c. A physician's (doctor of medicine, osteopathy, or podiatry), physician assistant's, or advanced registered nurse practitioner's prescription is required to establish medical necessity. The prescription shall state the member's name, diagnosis, prognosis, item(s) to be dispensed, quantity, and length of time the item is to be required and shall include the signature of the prescriber and the date of signature.

For items requiring prior authorization, a request shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior authorization is made using Form 470-5595, Outpatient Prior Authorization Request. See rule 441—78.28(249A) for prior authorization requirements.

d. Nonmedical items will not be covered. These include but are not limited to:

- (1) Physical fitness equipment, e.g., an exercycle, weights.
- (2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.
- (3) Self-help devices, e.g., safety grab bars, raised toilet seats.
- (4) Training equipment, e.g., speech teaching machines, braille training texts.
- (5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.
- (6) Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the member, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item which meets the member's medical needs. Payment will not be approved for items that serve duplicate functions. EXCEPTION: A second ventilator for which prior authorization has been granted. See 78.10(5)"k" for prior authorization requirements.

f. Consideration will be given to rental or purchase based on the price of the item and the length of time it would be required. The decision on rental or purchase shall be made by the Iowa Medicaid enterprise and be based on the most reasonable method to provide the equipment.

(1) The provider shall monitor rental payments up to 100 percent of the purchase price. At the point that total rent paid equals 100 percent of the purchase allowance, the member will be considered to own the item and no further rental payments will be made to the provider.

(2) Payment may be made for the purchase of an item even though rental payments may have been made for prior months. The rental of the equipment may be necessary for a period of time to establish that it will meet the identified need before the purchase of the equipment. When a decision is made to purchase after renting an item, all of the rental payments will be applied to the purchase allowance.

(3) EXCEPTION: Ventilators and oxygen systems shall be maintained on a rental basis for the duration of use.

(4) A deposit shall not be charged by a provider to a Medicaid member or any other person on behalf of a Medicaid member for rental of medical equipment.

g. Payment may be made for necessary repair, maintenance, and supplies for member-owned equipment. No payment may be made for repairs, maintenance, or supplies when the member is renting the item.

h. Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member's condition.

i. No allowance will be made for delivery, freight, postage, or other provider operating expenses for DME, prosthetic devices or medical supplies.

j. Reimbursement over the established fee schedule amount is allowed when prior authorization has been obtained. See 78.10(5)“*n*” for prior authorization requirements.

78.10(2) Durable medical equipment. DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

a. Durable medical equipment provided in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability is not separately payable.

EXCEPTIONS:

(1) Oxygen services in a nursing facility or an intermediate care facility for persons with an intellectual disability when all of the following requirements and conditions have been met:

1. A Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile is completed by a physician, physician assistant, or advanced registered nurse practitioner and qualifies the member in accordance with Medicare criteria.

2. Additional documentation shows that the member requires oxygen for 12 hours or more per day for at least 30 days.

3. Oxygen logs must be maintained by the provider. The time between any reading shall not exceed more than 45 days. The documentation maintained in the provider record must contain the following:

- The initial, periodic and ending reading on the time meter clock on each oxygen system, and
- The dates of each initial, periodic and ending reading, and
- Evidence of ongoing need for oxygen services.

4. The maximum Medicaid payment shall be based on the least costly method of oxygen delivery.

5. Oxygen prescribed “PRN” or “as necessary” is not payable.

6. Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system and costs for servicing and repair of equipment are included in the Medicaid payment and shall not be separately payable.

7. Payment is not allowed for oxygen services that are not documented according to the department of inspections and appeals requirements at 481—subrule 58.21(8).

(2) Speech generating devices for which prior authorization has been obtained. See 78.10(5)“*f*” for prior authorization requirements.

(3) Wheelchairs for members in an intermediate care facility for persons with an intellectual disability.

b. The types of durable medical equipment covered through the Medicaid program include, but are not limited to:

Automated medication dispenser.

Bathtub/shower chair, bench. See 78.10(5)“*g*” and “*j*” for prior authorization requirements.

Commode, shower commode chair. See 78.10(5)“*j*” for prior authorization requirements.

Decubitus equipment.

Dialysis equipment.

Diaphragm (contraceptive device).

Enclosed bed. See 78.10(5)“*a*” for prior authorization requirements.

Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.

Heat/cold application device.

Hospital bed and accessories.

Inhalation equipment. See 78.10(5)“*c*” for prior authorization requirements.

Insulin infusion pump. See 78.10(5)“*b*” and 78.10(5)“*e*” for prior authorization requirements.

Lymphedema pump.

Mobility device and accessories. See 78.10(5)“*i*” for prior authorization requirements.

Neuromuscular stimulator.

Oximeter.

Oxygen, subject to the limitations in 78.10(2)“a” and 78.10(2)“c.”

Patient lift. See 78.10(5)“h” for prior authorization requirements.

Phototherapy bilirubin light.

Protective helmet.

Seat lift chair.

Speech generating device. See 78.10(5)“f” for prior authorization requirements.

Traction equipment.

Ventilator.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary for members in accordance with Medicare criteria and as shown by supporting medical documentation. The physician, physician assistant, or advanced registered nurse practitioner shall document that other forms of treatment are contraindicated or have been tried and have not been successful and that oxygen therapy is required. EXCEPTION: Home oxygen equipment and oxygen are covered for children through three years of age when prescribed by a physician, physician assistant or advanced registered nurse practitioner. A pulse oximeter reading must be obtained yearly and documented in the provider and physician record.

(1) To identify the medical necessity for oxygen therapy, a Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile completed by a physician, physician assistant, or advanced registered nurse practitioner, shall qualify the member in accordance with Medicare criteria.

(2) If the member’s condition or need for oxygen services changes, the attending physician, physician assistant, or advanced registered nurse practitioner must adjust the documentation accordingly.

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from the physician, physician assistant, or advanced registered nurse practitioner of the specific activities for which portable oxygen is medically necessary.

(4) Payment for oxygen systems shall be made only on a rental basis for the duration of use.

(5) All accessories, disposable supplies, servicing, and repairing of oxygen systems are included in the monthly Medicaid payment for oxygen systems.

(6) Oxygen prescribed “PRN” or “as necessary” is not allowed.

d. Wheelchairs, wheelchair accessories, and wheelchair modifications are covered when they are medically necessary for mobility within the home, nursing facility, or intermediate care facility. Wheelchairs are defined as:

(1) Standard manual wheelchairs. Coverage of a standard manual wheelchair includes the following:

1. Complete set of tires/wheels and casters, any type;
2. Hand rims with or without projections;
3. Weight-specific components required by the patient-weight capacity of the wheelchair;
4. Elevating legrest, lower extension tube and upper hanger bracket;
5. Armrest (detachable, non-adjustable or adjustable) with or without arm pad;
6. Footrest (swingaway, detachable), including lower extension tube(s) and upper hanger bracket;
7. Standard size footplates;
8. Wheelchair bearings;
9. Caster fork, replacement only; and

10. All labor charges involved in the assembly of the wheelchair (including, but not limited to: front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).

(2) Standard manual wheelchair accessories that are separately billable and require prior authorization include the following:

1. Headrest extensions;
2. One-arm drive attachments;

3. Positioning accessories;
 4. Specialized skin protection seat and back cushions; and
 5. Anti-rollback devices.
- (3) Standard power wheelchair. Coverage of a standard power wheelchair requires prior authorization and includes the following:
1. Lap belt or safety belt;
 2. Battery charger, single mode;
 3. Complete set of tires/wheels and casters, any type;
 4. Legrests (fixed, swingaway, or detachable non-elevation legrests with or without calf pad);
 5. Footrests/foot platform (fixed, swingaway, detachable footrests or a foot platform without angle adjustment, single adjustable footplate);
 6. Armrests (fixed, swingaway, detachable non-adjustable height armrests with arm pad provided);
 7. Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by patient-weight capacity of the wheelchair;
 8. Any seat width and depth. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:
 - For standard duty, seat width and/or depth greater than 20 inches;
 - For heavy duty, seat width and/or depth greater than 22 inches;
 - For very heavy duty, seat width and/or depth greater than 24 inches;
 - EXCEPTION: For extra heavy duty, there is no separate billing;
 9. Any back width. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:
 - For standard duty, seat width and/or depth greater than 20 inches;
 - For heavy duty, seat width and/or depth greater than 22 inches;
 - For very heavy duty, seat width and/or depth greater than 24 inches;
 - EXCEPTION: For extra heavy duty, there is no separate billing;
 10. Non-expandable controller or standard proportional joystick (integrated or remote); and
 11. All labor charges involved in the assembly of the wheelchair (including, but not limited to: front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).
- (4) Standard power wheelchair accessories that are billed separately and require a prior authorization include the following:
1. Shoulder harness/straps or chest straps/vest;
 2. Elevating legrest;
 3. Angle adjustable footplates;
 4. Adjustable height armrests; and
 5. Expandable controller or nonstandard joystick (i.e., non-proportional or mini, compact or short throw proportional, or other alternative control device).
- (5) Customized items are payable with a prior authorization, in accordance with 42 CFR §414.224.
- 78.10(3) Prosthetic devices.** Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), physician assistant, or advanced registered nurse practitioner within the scope of practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. This does not require a determination that there is no possibility that the member's condition may improve sometime in the future.
- a. Prosthetic devices are not covered when dispensed to a member prior to the time the member undergoes a procedure which will make necessary the use of the device.
 - b. The types of prosthetic devices covered through the Medicaid program include, but are not limited to:
 - (1) Artificial eyes.
 - (2) Artificial limbs.
 - (3) Enteral delivery supplies and products. See 78.10(5) "l" for prior authorization requirements.
 - (4) Hearing aids. See rule 441—78.14(249A).

- (5) Orthotic devices. See 78.10(3)“c” for limitations on coverage of cranial orthotic devices.
- (6) Ostomy appliances.
- (7) Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member’s general condition.
- (8) Prosthetic shoes, orthopedic shoes. See rule 441—78.15(249A).
- (9) Tracheotomy tubes.
- (10) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross reference 78.28(5))

c. Cranial orthotic device. Payment shall be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is documentation supporting moderate to severe nonsynostotic positional plagiocephaly and either:

- (1) The member is 12 weeks of age but younger than 36 weeks of age and has failed to respond to a two-month trial of repositioning therapy; or
- (2) The member is 36 weeks of age but younger than 108 weeks of age and there is documentation of either of the following conditions:
 - 1. Cephalic index at least two standard deviations above the mean for the member’s gender and age; or
 - 2. Asymmetry of 12 millimeters or more in the cranial vault, skull base, or orbitotragial depth.

78.10(4) Medical supplies. Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. However, active pharmaceutical ingredients and excipients that are identified as preferred on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A are covered. Medical supplies shall not be dispensed at any one time in quantities exceeding a 31-day supply for active pharmaceutical ingredients and excipients or a three-month supply for all other items. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member’s caregiver for each refill.

a. The types of medical supplies and supplies necessary for the effective use of a payable item covered through the Medicaid program include, but are not limited to:

Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.

- Catheter (indwelling Foley).
- Colostomy and ileostomy appliances.
- Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.
- Diabetic supplies (including but not limited to blood glucose test strips, lancing devices, lancets, needles, syringes, and diabetic urine test supplies). See 78.10(5)“e” for prior authorization requirements.
- Dialysis supplies.
- Disposable catheterization trays or sets (sterile).
- Disposable irrigation trays or sets (sterile).
- Disposable saline enemas (e.g., sodium phosphate type).
- Dressings.
- Elastic antiembolism support stocking.
- Enema.
- Hearing aid batteries.
- Incontinence products (for members three years of age and older).
- Oral nutritional products. See 78.10(5)“m” for prior authorization requirements.
- Ostomy appliances and supplies.
- Respirator supplies.
- Shoes, diabetic.

Surgical supplies.

Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).

Diabetic supplies (including but not limited to lancing devices, lancets, needles and syringes, blood glucose test strips, and diabetic urine test supplies).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Ostomy appliances and supplies.

Shoes, diabetic.

78.10(5) *Prior authorization requirements.* Prior authorization pursuant to rule 441—79.8(249A) is required for the following medical equipment and supplies (Cross reference 78.28(1)):

a. Enclosed beds. Payment for an enclosed bed shall be approved when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis-related cognitive or communication impairment that results in risk to safety.

(2) The member's mobility puts the member at risk for injury.

b. External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

c. Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a member with a diagnosis of a lung disorder if all of the following conditions are met:

(1) Pulmonary function tests for the 12 months before the initiation of the vest demonstrate an overall significant decrease in lung function.

(2) The member resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.

(3) Treatment by flutter device failed or is contraindicated.

(4) Treatment by intrapulmonary percussive ventilation failed or is contraindicated.

(5) All other less costly alternatives have been tried.

d. Rescinded IAB 12/30/20, effective 3/1/21.

e. DME rebate agreements. If the department has a current agreement for a rebate with at least one manufacturer of a particular category of diabetic equipment or supplies (by healthcare common procedure coding system (HCPCS) code), prior authorization is required for any equipment or supplies in that category produced by a manufacturer that does not have a current agreement to provide a rebate to the department (other than supplies for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability). Prior approval shall be granted when the member's medical condition necessitates use of equipment or supplies produced by a manufacturer that does not have a current rebate agreement with the department.

f. Speech generating device. Payment shall be approved according to Medicare coverage criteria. Form 470-2145, Speech Generating Device System Selection, completed by a speech-language pathologist and a physician's, physician assistant's, or advanced registered nurse practitioner's prescription for a particular device shall be submitted with the request for prior authorization. In addition, documentation from a speech-language pathologist must include information on the member's educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. A minimum one-month trial period is required for all devices. The Iowa Medicaid enterprise consultant with expertise in speech-language pathology will evaluate each prior authorization request and make recommendations to the department.

g. Bathtub/shower chair, bench. Payment shall be approved for specialized bath equipment for members whose medical condition necessitates additional body support while bathing.

h. Patient lift, nonstandard. Payment shall be approved for a nonstandard lift, such as a portable, ceiling or electric lifter, when the member meets the Medicare criteria for a patient lift and a standard lifter (Hoyer type) will not work.

i. Power wheelchair attendant control. Payment shall be approved when the member has a power wheelchair and:

- (1) Has a sip 'n puff attachment, or
- (2) The medical documentation demonstrates the member's difficulty operating the wheelchair in tight space, or
- (3) The medical documentation demonstrates the member becomes fatigued.

j. Shower commode chairs. Prior authorization shall be granted when documentation from a physician, physician assistant, advanced registered nurse practitioner, physical therapist or occupational therapist indicates that the member:

- (1) Is unable to stand for the duration of a shower or is unable to get in or out of a bathtub, and
- (2) Needs upper body support while sitting, and
- (3) Needs to be tilted back for safety or pressure relief, if a tilt-in-space chair is requested.

k. Ventilator, secondary. Payment shall be approved according to the Medicare coverage criteria.

l. Enteral products and enteral delivery pumps and supplies. Payment shall be approved according to Medicare coverage criteria. EXCEPTION: The Medicare criteria for permanence is not required.

m. Oral nutritional products. Payment shall be approved when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for persons with an intellectual disability.

n. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved for bariatric equipment, pediatric equipment or other specialized medical equipment, supply, prosthetic or orthotic which:

- (1) Meets the definition of a code in the current healthcare common procedure coding system (HCPCS), and
- (2) Has an established Medicaid fee schedule amount that is inadequate to cover the provider's cost to obtain the equipment or supply.

o. Customized wheelchairs, subject to the requirements of 78.10(2)“d.”

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 8993B, IAB 8/11/10, effective 10/1/10; ARC 9256B, IAB 12/1/10, effective 1/1/11; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 4575C, IAB 7/31/19, effective 9/4/19; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5362C, IAB 12/30/20, effective 3/1/21]

441—78.11(249A) Ambulance service. Payment will be approved for ambulance service if it is required by the recipient's condition and the recipient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home or to a nursing facility. Payment for ambulance service to the nearest hospital for outpatient service will be approved only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged

from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

78.11(2) The Iowa Medicaid enterprise medical services unit shall determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician's confirmation when:

- a. The individual is admitted as a hospital inpatient or in an emergency situation.
- b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

78.11(3) When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements shall not be applicable. Approval for transfer shall be made by the local office of the department of human services prior to the transfer. When such a transfer is made, the following rate schedule shall apply:

- One patient - normal allowance
- Two patients - 3/4 normal allowance per patient
- Three patients - 2/3 normal allowance per patient
- Four patients - 5/8 normal allowance per patient

78.11(4) Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 441—paragraph 79.1(5) "j."

78.11(5) In the event that more than one ambulance service is called to provide ground ambulance transport, payment shall be made only to one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

This rule is intended to implement Iowa Code section 249A.4.

441—78.12(249A) Behavioral health intervention. Payment will be made for behavioral health intervention services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a mental disorder, subject to the limitations in this rule.

78.12(1) Definitions.

"Behavioral health intervention" means skill-building services that focus on:

1. Addressing the mental and functional disabilities that negatively affect a member's integration and stability in the community and quality of life;
2. Improving a member's health and well-being related to the member's mental disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member's best possible functional level; and
3. Promoting a member's mental health recovery and resilience through increasing the member's ability to manage symptoms.

"Licensed practitioner of the healing arts" or *"LPHA,"* as used in this rule, means a practitioner such as a physician (M.D. or D.O.), a physician assistant (PA), an advanced registered nurse practitioner (ARNP), a psychologist, a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who is licensed by the applicable state authority for that profession.

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

"Mental disorder" means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding intellectual disabilities, personality disorders, medication-induced

movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention.

78.12(2) Covered services.

a. Service setting.

(1) Community-based behavioral health intervention is available to a member living in a community-based environment. Services have a primary goal of assisting the member and the member's family to learn age-appropriate skills to manage behavior and regain or retain self-control. Depending on the member's age and diagnosis, specific services offered may include:

1. Behavior intervention,
2. Crisis intervention,
3. Skill training and development, and
4. Family training.

(2) Residential behavioral health intervention is available to members eligible for foster group care payment pursuant to 441—subrule 156.20(1). Services have the primary goal of assisting the member to prepare to transition to the community through learning age-appropriate skills to manage behavior and regain or retain self-control. Specific services offered include:

1. Behavior intervention,
2. Crisis intervention, and
3. Family training.

(3) Behavioral health intervention is not covered for members who are in an acute care or psychiatric hospital, a long-term care facility, or a psychiatric medical institution for children.

b. Crisis intervention. Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists.

(1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.

(3) Crisis intervention services do not include control room or other restraint activities.

c. Behavior intervention. Behavior intervention includes services designed to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.

(1) Interventions may address the following skills for effective functioning with family, peers, and community in an age-appropriate manner:

1. Cognitive flexibility skills,
2. Communication skills,
3. Conflict resolution skills,
4. Emotional regulation skills,
5. Executive skills,
6. Interpersonal relationship skills,
7. Problem-solving skills, and
8. Social skills.

(2) Behavior intervention shall be provided in a location appropriate for skill identification, teaching and development. Intervention may be provided in an individual, family, or group format as appropriate to meet the member's needs.

(3) Behavior intervention is covered only for Medicaid members aged 20 or under.

(4) Covered services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.

d. Family training. Family training is covered only for Medicaid members aged 20 or under.

(1) Family training services shall:

1. Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and

2. Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.

(2) Training provided must:

1. Be for the direct benefit of the member, and
2. Be based on a curriculum with a training manual.

e. Skill training and development. Skill training and development services are covered for Medicaid members aged 18 or over.

(1) Skill training and development shall consist of interventions to:

1. Enhance a member's independent living, social, and communication skills;
2. Minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and

3. Maximize a member's ability to live and participate in the community.

(2) Interventions may include training in the following skills for effective functioning with family, peers, and community:

1. Communication skills,
2. Conflict resolution skills,
3. Daily living skills,
4. Employment-related skills,
5. Interpersonal relationship skills,
6. Problem-solving skills, and
7. Social skills.

78.12(3) Excluded services.

a. Services that are habilitative in nature are not covered under behavioral health intervention. For purposes of this subrule, "habilitative services" means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

b. Respite, day care, education, and recreation services are not covered under behavioral health intervention.

78.12(4) Coverage requirements. Medicaid covers behavioral health intervention only when the following conditions are met:

a. A licensed practitioner of the healing arts acting within the practitioner's scope of practice under state law has diagnosed the member with a psychological disorder.

b. The licensed practitioner of the healing arts has recommended the behavioral health intervention as part of a plan of treatment designed to treat the member's psychological disorder. The plan of treatment shall be comprehensive in nature and shall detail all behavioral health services that the member may require, not only services included under behavioral health intervention.

(1) The member's need for services must meet specific individual goals that are focused to address:

1. Risk of harm to self or others,
2. Behavioral support in the community,
3. Specific skills impaired due to the member's mental illness, and
4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.

(2) Diagnosis and treatment plan development are covered services.

c. For a member under the age of 21, the licensed practitioner of the healing arts:

(1) Has, in cooperation with the managed care contractor, selected a standardized assessment instrument appropriate for baseline measurement of the member's current skill level in managing mental health needs;

(2) Has completed an initial formal assessment of the member using the instrument selected; and

(3) Completes a formal assessment every six months thereafter if continued services are ordered.

d. The behavioral health intervention provider has prepared a written services implementation plan that meets the requirements of subrule 78.12(5).

78.12(5) Approval of plan. The behavioral health intervention provider shall contact the member's managed care plan for authorization of the services.

a. Initial plan. The initial services implementation plan must meet all of the following criteria:

- (1) The plan conforms to the medical necessity requirements in subrule 78.12(6);
- (2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;
- (3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;
- (4) The provider meets the requirements of rule 441—77.12(249A); and
- (5) The plan does not exceed six months' duration.

b. Subsequent plans. The member's managed care plan may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)“a” if the services are recommended by a licensed practitioner of the healing arts who has:

- (1) Reexamined the member;
- (2) Reviewed the original diagnosis and treatment plan; and
- (3) Evaluated the member's progress, including a formal assessment as required by 78.12(4)“c”(3).

78.12(6) Medical necessity. Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, “medically necessary” means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by a mental disorder;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:

- (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
- (2) The professional literature regarding evidence-based practices in the field.

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[**ARC 8504B**, IAB 2/10/10, effective 3/22/10; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 1850C**, IAB 2/4/15, effective 4/1/15; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 5305C**, IAB 12/2/20, effective 2/1/21]

441—78.13(249A) Nonemergency medical transportation. The department makes available nonemergency medical transportation through a transportation brokerage. Medicaid members who are eligible for full Medicaid benefits and need transportation services so that they can receive Medicaid-covered services from providers enrolled with the Iowa Medicaid program may obtain transportation services consistent with this rule.

78.13(1) Covered services. Nonemergency medical transportation services available are limited to:

a. The most economical transportation appropriate to the needs of the member, provided to members eligible for nonemergency transportation when those members need transportation to providers enrolled in the Iowa Medicaid program for the receipt of goods or services covered by the Iowa Medicaid program. Consistent with the member's needs and subject to the limitations and restrictions set forth in this rule, subject to the advance approval of the broker, such transportation may include:

- (1) Mileage reimbursement to the member, if the member is the driver.
- (2) Mileage reimbursement to a volunteer or other responsible person, if the volunteer or other responsible person is the driver.
- (3) Taxi service.
- (4) Public transportation when public transportation is reasonably available and the member's condition does not preclude its use.
- (5) Wheelchair and stretcher vans.

(6) Airfare costs when the most appropriate mode of transport is by air, based on the member's medical condition.

b. Reimbursement for costs of the member's meals necessary during periods of transportation and medical treatment.

c. Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.

d. Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.

e. Reimbursement of a medically necessary escort's travel expenses when an escort is required because of the member's needs.

78.13(2) Exclusions. Nonemergency medical transportation is not available through the Iowa Medicaid program for:

a. Transportation to obtain services not covered by Iowa Medicaid;

b. Transportation to providers that are not enrolled in Iowa Medicaid;

c. Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);

d. Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;

e. Transportation to durable medical equipment providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;

f. Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;

g. Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and

h. Emergency transportation.

78.13(3) Conditions and limitations on covered services. Nonemergency medical transportation services are subject to the following limitations and conditions:

a. *Member request.* When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days' advance notice.

(1) Generally, members who require a ride from a transportation provider scheduled by the broker must contact the broker at least two business days in advance of the member's appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.

(2) If the member's nonemergency transportation need for a ride from a transportation provider scheduled by the broker makes the provision of two business days' notice impossible because of the member's urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs for a ride from a transportation provider scheduled by the broker are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days' notice. Examples of urgent trips include, but are not limited to:

1. Postsurgical or medical follow-up care specified by a health care provider;

2. Unexpected preoperative appointments;

3. Hospital discharges;

4. Appointments for new medical conditions or tests; and

5. Dialysis.

(3) The two-business-day advance notice obligation does not apply when the member requests only mileage reimbursement. To be eligible for mileage reimbursement:

1. The member must notify the broker no later than the day of the trip;

2. The transportation must be provided by a driver with a valid driver's license and insurance coverage on the vehicle at the time of the transport; and

3. The other requirements of rule 441—78.13(249A) must be met.

b. No free transportation alternatives available. Member transportation through the nonemergency medical transportation broker is not available to the member when the member is capable of securing the member's own transportation at no cost to the member (e.g., free-gas voucher programs).

c. No member transportation alternatives available. Members who have their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. For purposes of determining whether or not the member has the member's own transportation that is available to the member, the broker shall take into consideration:

- (1) Whether the member owns a vehicle;
- (2) Whether a member-owned vehicle is in working mechanical order and is licensed;
- (3) Whether the member has a valid driver's license and auto insurance;
- (4) Whether the member is unable to drive because of age, physical condition, cognitive impairment, or developmental limitations; and
- (5) Whether friends or family are available to transport the member to the member's medical appointment and receive mileage reimbursement.

d. Limitations on reimbursement for meals. Reimbursement for costs of members' meals necessary during periods of transportation and medical treatment is limited to situations in which:

- (1) The transportation being provided spans the entire meal period;
- (2) The one-way distance to or from the medical appointment is more than 50 miles;
- (3) The meal is necessary to satisfy the needs of the member or medically necessary escort; and
- (4) The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to Iowa Administrative Code rule 11—41.6(8A) and is supported by detailed receipts.

e. Limitations on reimbursement for lodging expenses. Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both, during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

f. Closest medical provider. Nonemergency medical transportation will only be provided to members to the closest qualified and enrolled Medicaid provider unless:

- (1) The difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or
- (2) The additional cost of transportation to the enrolled provider requested by the member is medically justified based on:

1. The member's previous relationship with the requested provider; or
2. The member's prior experience with the requested provider; or
3. The requested provider's special expertise or experience; or
4. A referral requiring the member to be seen by the requested provider.

g. Member scheduling obligations. Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

h. Abusive behavior. Members who are abusive or inappropriate may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

i. Member claim submission. Members must submit claims and supporting documentation to the broker within 120 days of the date of service. The broker shall deny member claims submitted more than 120 days from the date of service.

78.13(4) Grievance procedure. The broker shall establish an internal grievance procedure for members and transportation providers.

- a. Members may appeal to the department pursuant to 441—Chapter 7 as an “aggrieved person.”
- b. Transportation providers.
 - (1) Consent for state fair hearing.
 - 1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.
 - 2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member’s lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.
 - 3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider’s bringing the state fair hearing on the member’s behalf.
 - (2) For all transportation provider grievances not addressed by paragraph 78.13(4)“b,” the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 1264C, IAB 1/8/14, effective 3/1/14; ARC 1976C, IAB 4/29/15, effective 7/1/15]

441—78.14(249A) Hearing aids. Payment shall be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) Physician examination. The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

- a. Has been advised that it may be in the member’s best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.
- b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) Audiological testings. A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) Hearing aid evaluation. A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) Hearing aid selection. A physician or audiologist may recommend a specific brand or model appropriate to the member’s condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member’s condition.

78.14(5) Travel. When a member is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the member’s place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) Purchase of hearing aid. The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:

- a. A child needs the aid for speech development,

- b. The aid is needed for educational or vocational purposes,
- c. The aid is for a blind member,
- d. The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or
- e. Lack of binaural amplification poses a hazard to a member's safety.

78.14(7) Payment for hearing aids.

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist's fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer's invoice. Payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1) "a."

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid. (Cross reference 78.28(5) "a")

(2) Payment for a hearing aid costing more than \$650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross reference 78.28(5) "b"):

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 8008B, IAB 7/29/09, effective 8/1/09; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.15(249A) Orthopedic shoes. Payment shall be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) Definitions.

"Custom-molded shoe" means a shoe that:

- 1. Has been constructed over a cast or model of the recipient's foot;
- 2. Is made of leather or another suitable material of equal quality;
- 3. Has inserts that can be removed, altered, or replaced according to the recipient's conditions and needs; and
- 4. Has some form of closure.

"Depth shoe" means a shoe that:

- 1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
- 2. Is made from leather or another suitable material of equal quality;

3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

“Insert” means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient’s foot or is made over a model of the foot.

78.15(2) Prescription. The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:

1. The date.
2. The patient’s diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

78.15(3) Diagnosis. The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the current version of the International Classification of Diseases (ICD). A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

- (1) The reasons the recipient cannot be fitted with a depth shoe.
- (2) Pain.
- (3) Tissue breakdown or a high probability of tissue breakdown.
- (4) Any limitation on walking.

78.15(4) Frequency. Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

This rule is intended to implement Iowa Code section 249A.4.

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1) “*b*” with the following exceptions:

- (1) Services by staff psychiatrists, or
- (2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or
- (3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified

psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients' treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

(3) and (4) Rescinded IAB 2/5/03, effective 2/1/03.

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1)“b”(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1)“b”(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department of human services or department designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6)“b.”

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

c. Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor's degree in a human services related field from an accredited college or university; or

(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

d. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(7).

78.16(7) Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

a. Program documentation. Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative which provides the following day treatment program information:

(1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs "c" to "h" below.

(3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Program standards. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall:

1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—33.1(225C,230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.

2. Reflect how program continuity will be provided.

3. Reflect an interdisciplinary team of professionals and paraprofessionals.

4. Include a designated director who is a mental health professional as defined in rule 441—33.1(225C,230A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

5. Be provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor's degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified

occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

c. Program services. Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient's condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services (examples would include individual, group, and family therapy).

(2) Psychosocial rehabilitation services. Active treatment examples include, but are not limited to, individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment which reflect current functioning may be used as an update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program. Hours in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

d. Admission criteria. Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

- (1) The patient is at risk for exclusion from normative community activities or residence.
- (2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.
- (3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.

(4) The patient's principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient's behavior, and must be involved in the patient's treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(5) The patient has the capacity to benefit from the interventions provided.

e. Individual treatment plan. Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient's strengths and weaknesses and identify areas of therapeutic focus. The treatment goals which are general statements of consumer outcomes shall be related to identified strengths, weaknesses, and clinical needs

with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered either on the “National Register of Health Service Providers in Psychology” or the “Iowa Register of Health Service Providers for Psychology.” Approval will be evidenced by a signature of the physician or health service provider.

f. Discharge criteria. Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

(1) In the case of patient improvement:

1. The patient’s clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient’s developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.

2. Treatment goals in the individualized treatment plan have been achieved.

3. An aftercare plan has been developed that is appropriate to the patient’s needs and agreed to by the patient and family, custodian, or guardian.

(2) If the patient does not improve:

1. The patient’s clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.

2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

g. Coordination of services. Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

h. Stable milieu. The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient’s social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

i. Chronic mental illness. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(6).

This rule is intended to implement Iowa Code section 249A.4.

441—78.17(249A) Physical therapists. Payment will be approved for the same services payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4.

441—78.18(249A) Screening centers. Payment will be approved for health screening as defined in 441—subrule 84.1(1) for Medicaid members under 21 years of age.

78.18(1) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a screening center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:

- (1) Six screenings in the first year of life.
- (2) Four screenings between the ages of 1 and 2.
- (3) One screening a year at ages 3, 4, 5, and 6.
- (4) One screening a year at ages 8, 10, 12, 14, 16, 18, and 20.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

78.18(6) Rescinded IAB 12/3/08, effective 2/1/09.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment shall be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.19(249A) Rehabilitation agencies.

78.19(1) Coverage of services.

a. General provisions regarding coverage of services.

(1) Services are provided in the member's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. A nursing facility, an intermediate care facility for persons with an intellectual disability, or a hospital where services are provided is not considered a member's home.

1. Services provided to a member residing in a residential care facility licensed under Iowa Code section 135C.4 by the department of inspections and appeals are payable when the residential care facility submits a signed statement that the residential care facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes.

2. Under no circumstances will the IME or managed care organizations (MCOs) make payments to a rehabilitation agency for therapy provided to a member residing in a nursing facility or an intermediate care facility for persons with an intellectual disability. Physical, occupational, and speech therapy services for residents of the nursing facility, intermediate care facility for persons with an intellectual disability or hospital are the responsibility of the nursing facility, intermediate care facility for persons with an intellectual disability or hospital.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient's medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition, and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to 78.19(1) "b"(7) and (8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.

2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.

3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient's specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes in length.

4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to 78.19(1) "b"(7) and (8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to 78.19(1) "b"(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person's illness, injury, or disabling condition, be specific and effective treatment for the patient's medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as set forth in the department of public health, professional licensure division, 645—subrule 200.20(7).

(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient's condition in a reasonable amount of time based on the patient's restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.

(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient's injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient's medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient's level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

When a patient is under a restorative physical therapy program, the patient's condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient's condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient's progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the recipient's environment.

When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See number 4 below for guidelines under a significant change. Further diagnostic or trial therapy for the same issue would not be considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

1. There must be face-to-face interaction with a licensed therapist. (An aide's services will not be payable.)
2. Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)
3. Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.
4. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy.

A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.

5. For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person's daily life to the extent of the person's abilities.

6. Documentation should include any previous attempts to resolve problems using nontherapy personnel (i.e., residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.

7. Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.

8. Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. Occupational therapy services.

(1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the person's ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist as set forth in the department of public health, professional licensure division, rule 645—201.9(148B), and be reasonable and necessary for the treatment of the person's illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) "b" (7), (8), and (16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of 78.19(1) "b" (8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient which require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

d. Speech therapy services.

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis which will significantly improve a patient's practical,

functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities which are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) "b"(7), (8), and (16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then number "5" under 78.19(1) "b"(16) will not apply to trial therapy.

78.19(2) General guidelines for plans of treatment.

a. The minimum information to be included on medical information forms and treatment plans includes:

(1) The patient's current medical condition and functional abilities, including any disabling condition.

(2) The physician's signature and date (within the certification period).

(3) Certification period.

(4) Patient's progress in measurable statistics. (Refer to 78.19(1) "b"(16).)

(5) The place services are rendered.

(6) Dates of prior hospitalization (if applicable or known).

(7) Dates of prior surgery (if applicable or known).

(8) The date the patient was last seen by the physician (if available).

(9) A diagnosis relevant to the medical necessity for treatment.

(10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).

(11) A brief summary of the initial evaluation or baseline.

(12) The patient's prognosis.

(13) The services to be rendered.

(14) The frequency of the services and discipline of the person providing the service.

(15) The anticipated duration of the services and the estimated date of discharge (if applicable).

(16) Assistive devices to be used.

(17) Functional limitations.

(18) The patient's rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.

(19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).

(20) Quantitative, measurable, short-term and long-term functional goals.

(21) The period of time of a session.

(22) Prior treatment (history related to current diagnosis) if available or known.

b. The information to be included when developing plans for teaching, training, and counseling include:

- (1) To whom the services were provided (patient, family member, etc.).
- (2) Prior teaching, training, or counseling provided.
- (3) The medical necessity of the rendered services.
- (4) The identification of specific services and goals.
- (5) The date of the start of the services.
- (6) The frequency of the services.
- (7) Progress in response to the services.
- (8) The estimated length of time the services are needed.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 5305C, IAB 12/2/20, effective 2/1/21]

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4.

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program (Title XVIII of the Social Security Act). Payment will be made for sterilization in accordance with 78.1(16).

78.21(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.21(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.21(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a rural health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with 78.1(16).

78.22(2) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a family planning clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, which provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) Sterilization. Payment will be made for sterilization in accordance with 78.1(16).

78.23(2) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered

nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.23(3) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.23(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist shall be made on a fee for service basis.

a. Payment shall be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

e. Mileage at the same rate as in 78.1(8) when the following conditions are met:

(1) It is necessary for the psychologist to travel outside of the home community, and

(2) There is no qualified mental health professional more immediately available in the community, and

(3) The member has a medical condition which prohibits travel.

f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

c. Psychological examinations employing unusual or experimental instrumentation.

d. Individual and group psychotherapy without specification of condition, symptom, or complaint.

e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Rescinded IAB 10/12/94, effective 12/1/94.

78.24(5) The following services shall require review by a consultant to the department.

a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.

b. Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.25(1) Provider qualifications.

a. Prenatal and postpartum medical services shall be provided by a physician, a physician assistant, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.

b. Rescinded IAB 12/3/08, effective 2/1/09.

c. Education services and postpartum home visits shall be provided by a registered nurse.

d. Nutrition services shall be provided by a licensed dietitian.

e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) Services covered for all pregnant women. Services provided may include:

a. Prenatal and postpartum medical care.

b. Health education, which shall include:

(1) Importance of continued prenatal care.

(2) Normal changes of pregnancy including both maternal changes and fetal changes.

(3) Self-care during pregnancy.

(4) Comfort measures during pregnancy.

(5) Danger signs during pregnancy.

(6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.

(7) Preparation for baby including feeding, equipment, and clothing.

(8) Education on the use of over-the-counter drugs.

(9) Education about HIV protection.

c. Home visit.

d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).

e. Dental hygiene services within the scope of practice as defined by the dental board at 650—paragraph 10.5(3)“b.”

78.25(3) Enhanced services covered for women with high-risk pregnancies. Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented by Form 470-2942, Medicaid Prenatal Risk Assessment. An appropriately trained physician or advanced registered nurse practitioner must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

a. Rescinded IAB 12/3/08, effective 2/1/09.

b. Education, which shall include as appropriate education about the following:

- (1) High-risk medical conditions.
- (2) High-risk sexual behavior.
- (3) Smoking cessation.
- (4) Alcohol usage education.
- (5) Drug usage education.
- (6) Environmental and occupational hazards.
- c. Nutrition assessment and counseling, which shall include:
 - (1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.
 - (2) Ongoing nutritional assessment.
 - (3) Development of an individualized nutritional care plan.
 - (4) Referral to food assistance programs if indicated.
 - (5) Nutritional intervention.
- d. Psychosocial assessment and counseling, which shall include:
 - (1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.
 - (2) A profile of the client's family composition, patterns of functioning and support systems.
 - (3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.
- e. A postpartum home visit within two weeks of the child's discharge from the hospital, which shall include:
 - (1) Assessment of mother's health status.
 - (2) Physical and emotional changes postpartum.
 - (3) Family planning.
 - (4) Parenting skills.
 - (5) Assessment of infant health.
 - (6) Infant care.
 - (7) Grief support for unhealthy outcome.
 - (8) Parenting of a preterm infant.
 - (9) Identification of and referral to community resources as needed.

78.25(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a maternal health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's website.

78.26(1) Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:

- a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;

b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and

c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(4) Limits on covered services.

a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.

b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.

c. Preprocedure review by the IME medical services unit is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from the IME medical services unit. (Cross reference 78.28(7))

This rule is intended to implement Iowa Code section 249A.4.

[ARC 8205B, IAB 10/7/09, effective 11/11/09; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.27(249A) Home- and community-based habilitation services. Payment for habilitation services will only be made to providers enrolled to provide habilitation through the Iowa Medicaid enterprise. Effective March 17, 2022, payment shall only be made for services provided to members in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.27(1) Definitions.

“*Adult*” means a person who is 18 years of age or older.

“*Assessment*” means the review of the current functioning of the member using the service in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

“*Benefits education*” means providing basic information to understand and access appropriate resources to pursue employment, and knowledge of work incentives and the Medicaid for employed persons with disabilities (MEPD) program. Benefits education may include gathering information needed to pursue work incentives and offering basic financial management information to members, families, guardians and legal representatives.

“*Care coordinator*” means the professional who assists members in care coordination as described in paragraph 78.53(1) “b.”

“*Career exploration*,” also referred to as “career planning,” means a person-centered, comprehensive employment planning and support service that provides assistance for waiver program participants to obtain, maintain or advance in competitive employment or self-employment. Career exploration is a focused, time-limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state’s minimum wage. The outcome of this service is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.

“*Career plan*” means a written plan documenting the member’s stated career objective and used to guide individual employment support services for achieving competitive, integrated employment at or above the state’s minimum wage.

“*Case management*” means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

“*Comprehensive service plan*” means an individualized, person-centered, and goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

“*Customized employment*” means an approach to supported employment which individualizes the employment relationship between employees and employers in ways that meet the needs of both. Customized employment is based on an individualized determination of the strengths, needs, and interests of the person with a disability and is also designed to meet the specific needs of the employer.

Customized employment may include employment developed through job carving, self-employment or entrepreneurial initiatives, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of the individual with a disability. Customized employment assumes the provision of reasonable accommodations and supports necessary for the individual to perform the functions of a job that is individually negotiated and developed.

“Department” means the Iowa department of human services.

“Emergency” means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

“HCBS” means home- and community-based services.

“Individual employment” means employment in the general workforce where the member interacts with the general public to the same degree as nondisabled persons in the same job, and for which the member is paid at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons without disabilities.

“Individual placement and support” means an evidence-based supported employment model that helps people with mental illness to seek and obtain employment.

“Integrated community employment” means work (including self-employment) for which an individual with a disability is paid at or above minimum wage and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by employees who are not disabled, where the individual interacts with other persons who are not disabled to the same extent as others who are in comparable positions, and which presents opportunities for advancement that are similar to those for employees who are not disabled. In the case of an individual who is self-employed, the business results in an income that is comparable to the income received by others who are not disabled and are self-employed in similar occupations.

“Integrated health home” means the provision of services to enrolled members as described in subrule 78.53(1).

“Interdisciplinary team” means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member’s need for services.

“ISIS” means the department’s individualized services information system.

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

“Member” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

“Supported employment” means the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state’s minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided through many different service models.

“Supported self-employment” includes services and supports that assist the participant in achieving self-employment through the operation of a business; however, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include aid to the individual in identifying potential business opportunities; assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; identification of the supports necessary for the individual to

operate the business; and ongoing assistance, counseling and guidance once the business has been launched.

“*Sustained employment*” means an individual employment situation that the member maintains over time but not for less than 90 calendar days following the receipt of employment services and supports.

78.27(2) Member eligibility. To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

a. Risk factors. The member has at least one of the following risk factors:

(1) The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization) more than once in the member’s life; or

(2) The member has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

b. Need for assistance. The member has a need for assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

(1) The member is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history.

(2) The member requires financial assistance for out-of-hospital maintenance and is unable to procure this assistance without help.

(3) The member shows severe inability to establish or maintain a personal social support system.

(4) The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, and medication management.

(5) The member exhibits inappropriate social behavior that results in a demand for intervention.

c. Income. The countable income used in determining the member’s Medicaid eligibility does not exceed 150 percent of the federal poverty level.

d. Needs assessment. The interRAI - Child and Youth Mental Health (ChYMH) for youth aged 16 to 18 or the interRAI - Community Mental Health (CMH) for those aged 19 and older has been completed, and based on information submitted on the information submission tool and other supporting documentation as relevant, the IME medical services unit has determined that the member is in need of home- and community-based habilitation services. The interRAI - Child and Youth Mental Health (ChYMH) and the interRAI - Community Mental Health (CMH) information submission tools are available on request from the IME medical services unit. Copies of the information submission tool for an individual are available to that individual from the individual’s case manager, integrated health home care coordinator, or managed care organization. The designated case manager or integrated health home care coordinator shall:

(1) Arrange for the completion of the interRAI, before services begin and annually thereafter.

(2) Use the information submission tool and other supporting documentation as relevant to develop a comprehensive service plan as specified in subrule 78.27(4), before services begin and annually thereafter.

e. Plan for service. The department has approved the member’s comprehensive service plan for home- and community-based habilitation services. Home- and community-based habilitation services included in a comprehensive service plan or treatment plan that has been validated through ISIS shall be considered approved by the department. Home- and community-based habilitation services provided before approval of a member’s eligibility for the program cannot be reimbursed.

(1) The member’s comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4). A service plan may change at any time due to a significant change in the member’s needs.

(2) The member’s habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(3) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

78.27(3) Application for services. The member, case manager or integrated health home care coordinator shall apply for habilitation services on behalf of a member by contacting the IME medical

services unit. The department shall issue a notice of decision to the applicant when financial eligibility and needs-based eligibility determinations have been completed.

78.27(4) Comprehensive service plan. Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan or treatment plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

a. Development. A comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.

(1) The case manager or the integrated health home care coordinator shall establish an interdisciplinary team as selected by the member or the member's legal representative. The team shall include the case manager or integrated health home care coordinator and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved with the member.

(2) With assistance from the member and the interdisciplinary team, the case manager or integrated health home care coordinator shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.

(9) The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved by the IME medical services unit in ISIS before services are implemented. Services provided before the approval date are not payable. The written comprehensive service plan or treatment plan must be completed, signed and dated by the case manager or integrated health home care coordinator within 30 calendar days after plan approval.

(10) Any changes to the comprehensive service plan or treatment plan must be approved by the IME medical services unit for members not eligible to enroll in a managed care organization in ISIS before the implementation of services. Services provided before the approval date are not payable.

b. Service goals and activities. The comprehensive service plan shall:

(1) Identify observable or measurable individual goals.

(2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.

(4) List all Medicaid and non-Medicaid services received by the member and identify:

1. The name of the provider responsible for delivering the service;

2. The funding source for the service; and

3. The number of units of service to be received by the member.

(5) Identify for a member receiving home-based habilitation:

1. The member's living environment at the time of enrollment;

2. The number of hours per day of on-site staff supervision needed by the member; and

3. The number of other members who will live with the member in the living unit.

(6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

c. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member’s rights, including maintenance of personal funds and self-administration of medications;
- (2) The need for the restriction; and
- (3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

d. Emergency plan. The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:

(1) The member’s interdisciplinary team shall identify in the comprehensive service plan or treatment plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.

(2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member’s needs change.

(3) Providers of applicable services shall provide for emergency backup staff.

e. Plan approval. Services shall be entered into ISIS based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2)“e.”

78.27(5) Requirements for services. Home- and community-based habilitation services shall be provided in accordance with the following requirements:

a. The services shall be based on the member’s needs as identified in the member’s comprehensive service plan.

b. The services shall be delivered in the least restrictive environment appropriate to the needs of the member.

c. The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member’s life goals.

d. Service components that are the same or similar shall not be provided simultaneously.

e. Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.

f. Reimbursement is not available for room and board.

g. Services shall be billed in whole units.

h. Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) Case management. Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Scope. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Exclusions.

(1) Payment shall not be made for case management provided to a member who is enrolled for integrated health home services under rule 441—78.53(249A) except during the transition to the integrated health homes.

(2) Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

78.27(7) Home-based habilitation. “Home-based habilitation” means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living in the community.

a. Scope. Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan. Covered supports include:

- (1) Adaptive skill development;
- (2) Assistance with activities of daily living;
- (3) Community inclusion;
- (4) Transportation;
- (5) Adult educational supports;
- (6) Social and leisure skill development;
- (7) Personal care; and
- (8) Protective oversight and supervision.

b. Exclusions. Home-based habilitation payment shall not be made for the following:

- (1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.
- (2) Service activities associated with vocational services, day care, medical services, or case management.
- (3) Transportation to and from a day program.
- (4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.
- (5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or "bundled" service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) Day habilitation. "Day habilitation" means services that provide opportunities and support for community inclusion and build interest in and develop skills for active participation in recreation, volunteerism and integrated community employment. Day habilitation provides assistance with acquisition, retention, or improvement of socialization, community participation, and daily living skills.

a. Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, positive social behavior, greater independence, and personal choice. Services focus on supporting the member to participate in the community, develop social roles and relationships, and increase independence and the potential for employment. Services are designed to assist the member to attain or maintain the member's individual goals as identified in the member's comprehensive service plan. Services may also provide wraparound support secondary to community employment. Day habilitation activities may include:

- (1) Identifying the member's interests, preferences, skills, strengths and contributions,
- (2) Identifying the conditions and supports necessary for full community inclusion and the potential for competitive integrated employment,
- (3) Planning and coordination of the member's individualized daily and weekly day habilitation schedule,
- (4) Developing skills and competencies necessary to pursue competitive integrated employment,
- (5) Participating in community activities related to hobbies, leisure, personal health, and wellness,
- (6) Participating in community activities related to cultural, civic, and religious interests,
- (7) Participating in adult learning opportunities,
- (8) Participating in volunteer opportunities,
- (9) Training and education in self-advocacy and self-determination to support the member's ability to make informed choices about where to live, work, and recreate,
- (10) Assistance with behavior management and self-regulation,
- (11) Use of transportation and other community resources,

(12) Assistance with developing and maintaining natural relationships in the community,
(13) Assistance with identifying and using natural supports,
(14) Assistance with accessing financial literacy and benefits education,
(15) Other activities deemed necessary to assist the member with full participation in the community, developing social roles and relationships, and increasing independence and the potential for employment.

b. Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member's home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month.

c. Expected outcome of service. The expected outcome of day habilitation services is active participation in the community in which the member lives, works, and recreates. Members are expected to have opportunities to interact with individuals without disabilities in the community, other than those providing direct services, to the same extent as individuals without disabilities.

d. Setting. Day habilitation shall take place in community-based, nonresidential settings separate from the member's residence. Family training may be provided in the member's home.

e. Duration. Day habilitation services shall be furnished as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

f. Unit of service. A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

g. Concurrent services. A member's comprehensive service plan may include two or more types of nonresidential habilitation services (e.g., day habilitation, individual supported employment, long-term job coaching, small-group supported employment, and prevocational services). However, more than one service may not be billed during the same period of time (e.g., the same hour).

h. Transportation. When transportation is provided to the day habilitation service location from the member's home and from the day habilitation service location to the member's home, the day habilitation provider may bill for the time spent transporting the member.

i. Exclusions. Day habilitation payment shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving day habilitation services.

(2) Compensation to members for participating in day habilitation.

(3) Support for members volunteering in for-profit organizations and businesses.

(4) Support for members volunteering to benefit the day habilitation service provider.

78.27(9) Prevocational service habilitation. "Prevocational services" means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

a. Scope. Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to the ability to communicate effectively with supervisors, coworkers and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment.

Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services.

(1) Career exploration. Career exploration activities are designed to develop an individual career plan and facilitate the member's experientially based informed choice regarding the goal of individual employment. Career exploration may be provided in small groups of no more than four members to participate in career exploration activities that include business tours, attending industry education events, benefit information, financial literacy classes, and attending career fairs. Career exploration may be authorized for up to 34 hours, to be completed over 90 days in the member's local community or nearby communities and may include but is not limited to the following activities:

1. Meeting with the member and the member's family, guardian or legal representative to introduce them to supported employment and explore the member's employment goals and experiences,

2. Business tours,

3. Informational interviews,

4. Job shadows,

5. Benefits education and financial literacy,

6. Assistive technology assessment, and

7. Job exploration events.

(2) Expected outcome of service.

1. The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

2. The expected outcome of the career exploration activity is a written career plan that will guide employment services which lead to community employment or self-employment for the member.

b. Setting. Prevocational services shall take place in community-based nonresidential settings.

c. Concurrent services. A member's individual service plan may include two or more types of nonresidential habilitation services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

d. Exclusions. Prevocational services payment shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.

(2) Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

(3) Compensation to members for participating in prevocational services.

(4) Support for members volunteering in for-profit organizations and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g., hospitals, nursing homes), and support for members volunteering to benefit the service provider.

(5) The provision of vocational services delivered in facility-based settings where individuals are supervised for the primary purpose of producing goods or performing services or where services are aimed at teaching skills for specific types of jobs rather than general skills.

(6) A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the individual in continuing prevocational services or any employment situation similar to sheltered employment.

e. Limitations.

(1) Time limitation for members starting prevocational services. For members starting prevocational services after May 4, 2016, participation in these services is limited to 24 calendar months. This time limit can be extended to continue beyond 24 months if one or more of the following conditions apply:

1. The member who is in prevocational services is also working in either individual or small-group community employment for at least the number of hours per week desired by the member, as identified in the member's current service plan; or

2. The member who is in prevocational services is also working in either individual or small-group community employment for less than the number of hours per week the member desires, as identified in the member's current service plan, but the member has services documented in the member's current service plan, or through another identifiable funding source (e.g., Iowa vocational rehabilitation services (IVRS)), to increase the number of hours the member is working in either individual or small-group community employment; or

3. The member is actively engaged in seeking individual or small-group community employment or individual self-employment, and services for this are included in the member's current service plan or services funded through another identifiable funding source (e.g., IVRS) are documented in the member's service plan; or

4. The member has requested supported employment services from Medicaid and IVRS in the past 24 months, and the member's request has been denied or the member has been placed on a waiting list by both Medicaid and IVRS; or

5. The member has been receiving individual supported employment services (or comparable services available through IVRS) for at least 18 months without obtaining individual or small-group community employment or individual self-employment; or

6. The member is participating in career exploration activities as described in subparagraph 78.27(9) "a"(1).

(2) Time limitation for members enrolled in prevocational services. For members enrolled in prevocational services on or before May 4, 2016, participation in these services is limited to 90 business days beyond the completion of the career exploration activity including the development of the career plan described in subparagraph 78.27(9) "a"(1). This time limit can be extended as stated in paragraphs 78.27(9) "e"(1) "1" through "6." If the criteria in paragraphs 78.27(9) "e"(1) "1" through "6" do not apply, the member will not be reauthorized to continue prevocational services.

78.27(10) Supported employment services.

a. Individual supported employment. Individual supported employment involves supports provided to, or on behalf of, the member that enable the member to obtain and maintain individual employment. Services are provided to members who need support because of their disabilities.

(1) Scope. Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(2) Expected outcome of service. The expected outcome of this service is sustained employment, or self-employment, paid at or above the minimum wage or the customary wage and level of benefits paid by an employer, in an integrated setting in the general workforce, in a job that meets personal and career goals. Successful transition to long-term job coaching, if needed, is also an expected outcome of this service. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Individual supported employment services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

(4) Individual employment strategies include but are not limited to: customized employment, individual placement and support, and supported self-employment. Service activities are individualized and may include any combination of the following:

1. Benefits education.
2. Career exploration (e.g., tours, informational interviews, job shadows).

3. Employment assessment.
4. Assistive technology assessment.
5. Trial work experience.
6. Person-centered employment planning.
7. Development of visual/traditional résumés.
8. Job-seeking skills training and support.
9. Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the member; employer needs analysis).
10. Job analysis (e.g., work site assessment or job accommodations evaluation).
11. Identifying and arranging transportation.
12. Career advancement services (e.g., assisting a member in making an upward career move or seeking promotion from an existing employer).
13. Reemployment services (if necessary due to job loss).
14. Financial literacy and asset development.
15. Other employment support services deemed necessary to enable the member to obtain employment.
16. Systematic instruction and support during initial on-the-job training including initial on-the-job training to stabilization.
17. Engagement of natural supports during initial period of employment.
18. Implementation of assistive technology solutions during initial period of employment.
19. Transportation of the member during service hours.
20. Initial on-the-job training to stabilization activity.

(5) Self-employment. Individual employment may also include support to establish a viable self-employment opportunity, including home-based self-employment. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed under subparagraph 78.27(10)“a”(4), assistance to establish self-employment may include:

1. Aid to the member in identifying potential business opportunities.
 2. Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.
 3. Identification of the long-term supports necessary for the individual to operate the business.
- b. Long-term job coaching.* Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(1) Scope. Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in individual employment absent the provision of supports. Long-term job coaching services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement.

(2) Expected outcome of service. The expected outcome of this service is sustained employment paid at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the member’s personal and career goals. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Long-term job coaching services shall take place in integrated work settings. For self-employment, the member’s home can be considered an integrated work setting. Employment in the service provider’s organization (not including a sheltered workshop or similar type of work setting) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities, or with the general public, and if the position would exist within the provider’s organization were the provider not being paid to provide the job coaching to the member.

(4) Service activities. Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, and which allows for the reduction of long-term job coaching over time. Services are individualized, and service plans are adjusted as support needs change and may include any combination of the following activities with or on behalf of the member:

1. Job analysis.
2. Job training and systematic instruction.
3. Training and support for use of assistive technology/adaptive aids.
4. Engagement of natural supports.
5. Transportation coordination.
6. Job retention training and support.
7. Benefits education and ongoing support.
8. Supports for career advancement.
9. Financial literacy and asset development.
10. Employer consultation and support.
11. Negotiation with employer on behalf of the member (e.g., accommodations; employment conditions; access to natural supports; and wage and benefits).
12. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting.
13. Transportation of the member during service hours.
14. Career exploration services leading to increased hours or career advancement.

(5) Self-employment long-term job coaching. Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment. In addition to the activities listed under subparagraph 78.27(10)“b”(4), assistance to maintain self-employment may include:

1. Ongoing identification of the supports necessary for the individual to operate the business;
 2. Ongoing assistance, counseling and guidance to maintain and grow the business; and
 3. Ongoing benefits education and support.
- (6) The hours of support for long-term job coaching are based on the identified needs of the member as documented in the member’s comprehensive service plan.

c. Small-group supported employment. Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and planning leading to referral for services to obtain individual integrated employment or self-employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(1) Scope. Small-group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces. Examples include but are not limited to mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in integrated business settings; and small-group activities focused on career exploration and development of strengths and skills that contribute to successful participation in individual community employment.

(2) Expected outcome of service. Small-group supported employment services are expected to enable the member to make reasonable and continued progress toward individual employment. Participation in small-group supported employment services is not a prerequisite for individual supported employment services. The expected outcome of the service is sustained paid employment and skill development which leads to individual employment in the community.

(3) Setting. Small-group supported employment services shall take place in integrated, community-based nonresidential settings separate from the member’s residence.

(4) Service activities. Small-group supported employment services may include any combination of the following activities:

1. Employment assessment.
2. Person-centered employment planning.
3. Job placement (limited to service necessary to facilitate hire into individual employment paid at minimum wage or higher for a member in small-group supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave).
4. Job analysis.
5. On-the-job training and systematic instruction.
6. Job coaching.
7. Transportation planning and training.
8. Benefits education.
9. Career exploration services leading to career advancement outcomes.
10. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting.
11. Transportation of the member during service hours.

d. Service requirements for all supported employment services.

(1) Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from work for the member. If none of these options are available to a member, transportation between the member's place of residence and the employment or service location may be included as a component part of supported employment services.

(2) Personal care or personal assistance and protective oversight may be a component part of supported employment services, but may not comprise the entirety of the service.

(3) Activities performed on behalf of a member receiving long-term job coaching or individual or small-group supported employment shall not comprise the entirety of the service.

(4) Concurrent services. A member's individual service plan may include two or more types of nonresidential services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

(5) Integration requirements. In the performance of job duties, the member shall have regular contact with other employees or members of the general public who do not have disabilities, unless the absence of regular contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(6) Compensation. Members receiving these services are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. For supported self-employment, the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. For small-group supported employment, if the member is not compensated at or above minimum wage, the compensation to the member shall be in accordance with all applicable state and federal labor laws and regulations.

e. Limitations. Supported employment services are limited as follows:

(1) Total monthly costs of supported employment may not exceed the monthly cap on the cost of waiver services set for the individual waiver program.

(2) In absence of a monthly cap on the cost of waiver services, the total monthly cost of all supported employment services may not exceed \$3,059.29 per month.

(3) Individual supported employment is limited to 60 hourly units per calendar year.

(4) Long-term job coaching is limited in accordance with 441—subrule 79.1(2).

(5) Small-group supported employment is limited to 160 units per week.

f. Exclusions. Supported employment services payments shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that the service is not available to the individual under these programs shall be maintained in the service plan of each member receiving individual supported employment or long-term job coaching services.

(2) Incentive payments, not including payments for coworker supports, made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing and stabilizing members in day activity programs, work activity programs, sheltered workshop programs or other similar types of vocational or prevocational services furnished in specialized facilities that are not a part of the general workplace.

(6) Supports for placement and stabilization in volunteer positions or unpaid internships. Such volunteer learning and unpaid training activities that prepare a person for entry into the general workforce are addressed through prevocational services and career exploration activities.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not related to integrated individual employment participation or is not member-specific.

(9) Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

78.27(11) Adverse service actions.

a. Denial. Services shall be denied when the department determines that:

(1) The member is not eligible for or in need of home- and community-based habilitation services.

(2) The service is not identified in the member's comprehensive service plan or treatment plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(5) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 120 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 120 consecutive days, the department will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. Appeal rights. The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

78.27(12) County reimbursement. Rescinded IAB 7/11/12, effective 7/1/12.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 9311B, IAB 12/29/10, effective 1/1/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5307C, IAB 12/2/20, effective 2/1/21]

441—78.28(249A) List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician, physician assistant, or advanced registered nurse practitioner which are subject to prior authorization or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Rescinded IAB 12/30/20, effective 3/1/21.

c. Enteral products and enteral delivery pumps and supplies. Payment shall be approved pursuant to the criteria at 78.10(5) “l.”

d. Rescinded IAB 5/11/05, effective 5/1/05.

e. Speech generating device. Payment shall be approved pursuant to the criteria at 78.10(5) “f.”

f. Preprocedure review by the IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and on the criteria established by the department and the IME medical services unit. If not so approved by the IME medical services unit, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from the IME medical services unit.

g. Enclosed beds. Payment shall be approved pursuant to the criteria at 78.10(5) “a.”

h. Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross reference 78.10(2) “c”)

i. Oral nutritional products. Payment shall be approved pursuant to the criteria at 78.10(5) “m.”

j. Vest airway clearance system. Payment shall be approved pursuant to the criteria at 78.10(5) “c.”

k. DME rebate agreements. Payment will be approved pursuant to the criteria at 78.10(5) “e.”

l. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved pursuant to the criteria at 78.10(5) “n.”

m. Bathtub/shower chair, bench. Payment shall be approved pursuant to the criteria at 78.10(5) “g.”

n. Patient lift, nonstandard. Payment shall be approved pursuant to the criteria at 78.10(5) “h.”

o. Power wheelchair attendant control. Payment shall be approved pursuant to the criteria at 78.10(5) “i.”

- p.* Shower commode chair. Payment shall be approved pursuant to the criteria at 78.10(5) “*j.*”
- q.* Ventilator, secondary. Payment shall be approved pursuant to the Medicare coverage criteria.
- r.* Customized wheelchairs, subject to the requirements of 78.10(2) “*d.*”

78.28(2) Notwithstanding the provisions of 78.28(1) “*a.*” under both Medicaid fee-for-service and managed care administration, at least one form of each of the following drugs for medication-assisted treatment as approved by the United States Food and Drug Administration for treatment of substance use disorder or overdose treatment will be available without prior authorization:

- a.* Buprenorphine,
- b.* Buprenorphine and naloxone combination,
- c.* Methadone,
- d.* Naltrexone, and
- e.* Naloxone.

For the purpose of this subrule, “medication-assisted treatment” means the medically monitored use of certain substance use disorder medications in combination with treatment services.

78.28(3) Dental services. Dental services which require prior approval are as follows:

a. The following periodontal services:

- (1) Periodontal scaling and root planing. Payment will be approved pursuant to the criteria at 78.4(4) “*b.*”
- (2) Pedicle soft tissue graft, free soft tissue graft, and subepithelial tissue graft. Payment will be approved pursuant to the criteria at 78.4(4) “*d.*”
- (3) Periodontal maintenance therapy. Payment will be approved pursuant to the criteria at 78.4(4) “*e.*”
- (4) Tissue regeneration. Payment will be approved pursuant to the criteria at 78.4(4) “*f.*”
- (5) Localized delivery of antimicrobial agents. Payment will be approved pursuant to the criteria at 78.4(4) “*g.*”

b. The following prosthetic services:

- (1) A removable partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) “*b.*”
- (2) A fixed partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) “*d.*”
- (3) A removable partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) “*c.*”
- (4) A fixed partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) “*e.*”
- (5) Dental implants and related services. Payment will be approved pursuant to the criteria at 78.4(7) “*k.*”
- (6) Replacement of complete or partial dentures in less than a five-year period. Payment will be approved pursuant to the criteria at 78.4(7) “*l.*”
- (7) A complete or partial denture rebase. Payment will be approved pursuant to the criteria at 78.4(7) “*m.*”
- (8) An oral appliance for obstructive sleep apnea. Payment will be approved pursuant to the criteria at 78.4(7) “*n.*”

c. The following orthodontic services:

- (1) Minor treatment to control harmful habits. Payment will be approved pursuant to the criteria at 78.4(8) “*a.*”
- (2) Interceptive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8) “*b.*”
- (3) Comprehensive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8) “*c.*”

d. The following restorative services:

- (1) Laboratory-fabricated crowns other than stainless steel. Payment will be approved pursuant to the criteria at 78.4(3) “*d*”(3).

(2) Crowns with noble or high noble metals. Payment will be approved pursuant to the criteria at 78.4(3) "d"(4).

e. Endodontic retreatment of a tooth. Payment will be approved pursuant to the criteria at 78.4(5) "d."

f. Occlusal guard. Payment will be approved pursuant to the criteria at 78.4(9) "g."

78.28(4) Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

a. A second lens correction within a 24-month period for members eight years of age and older. Payment shall be made when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.

d. Photochromatic tint. Approval shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Press-on prisms. Approval shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross references 78.6(4), 441—78.7(249A), and 78.1(18))

78.28(5) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person's hearing that would require a different hearing aid. (Cross reference 78.14(7) "d"(1))

b. A hearing aid costing more than \$650. The department shall approve payment for either of the following purposes (Cross reference 78.14(7) "d"(2)):

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(6) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross reference 441—78.1(249A))

b. All inpatient hospital admissions are subject to retrospective review. Payment for inpatient hospital admissions which are retrospectively reviewed is approved when the claim meets the criteria for inpatient hospital care as determined by the IME medical services unit. Criteria are available from the IME medical services unit. (Cross reference 441—78.3(249A))

c. Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the department. The criteria are available from the IME medical services unit.

78.28(7) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

b. Preprocedure review is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the department.

78.28(8) All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

a. Approval shall be granted if ACT services are determined to be medically necessary. Approval shall be limited to no more than 180 days.

b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

78.28(9) Nursing, psychosocial, developmental therapies and personal care services provided by a licensed child care center for members aged 20 or under require prior approval and shall be approved if the services are determined to be medically necessary. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation and shall identify the types and service delivery levels of all other services provided to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of nursing, home health aide or behavior intervention hours per day, the number of days per week, and the number of weeks or months of service based on the plan of care using a combined hourly rate.

78.28(10) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's

physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.9(10))

78.28(11) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross reference 78.10(3) "b")

78.28(12) High-technology radiology procedures.

a. Except as provided in paragraph 78.28(12) "b," the following radiology procedures require prior approval:

- (1) Magnetic resonance imaging (MRIs);
- (2) Computed tomography (CTs), including combined abdomen and pelvis CT scans;
- (3) Computed tomographic angiographs (CTAs);
- (4) Positron emission tomography (PETs); and
- (5) Magnetic resonance angiography (MRAs).

b. Notwithstanding paragraph 78.28(12) "a," prior authorization is not required when any of the following applies:

(1) Radiology procedures are billed on a CMS 1500 claim for places of service "hospital inpatient" (POS 21) or "hospital emergency room" (POS 23), or on a UB04 claim with revenue code 45X;

(2) The member has Medicare coverage;

(3) A radiology procedure is ordered or requested by the department of human services, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

c. Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.9(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

d. Required requests for prior approval of radiology procedures must be submitted to the department of human services.

e. When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member's receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on Form 470-5595, Outpatient Prior Authorization Request, and approved before any claim for payment is submitted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0631C, IAB 3/6/13, effective 5/1/13; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 1696C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4575C, IAB 7/31/19, effective 9/4/19; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5362C, IAB 12/30/20, effective 3/1/21]

441—78.29(249A) Behavioral health services. Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner's scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) Limitations.

- a. An assessment and a treatment plan are required.
- b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) Exclusions. Payment will not be approved for the following services:

- a. Services provided in a medical institution.
- b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.
- c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.
- d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) Payment.

- a. Payment shall be made only for time spent in face-to-face consultation with the member.
- b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9649B, IAB 8/10/11, effective 8/1/11]

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services.

78.30(1) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

- a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.
- b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.30(2) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a birth center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.31(249A) Hospital outpatient services.

78.31(1) Covered hospital outpatient services. Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs “g” to “m” are subject to a random sample retrospective review for medical necessity by the IME medical services unit. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs “a” to “f” shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs “g” to “m” shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

- a. Emergency service.
- b. Outpatient surgery.
- c. Laboratory, X-ray and other diagnostic services.
- d. General or family medicine.
- e. Follow-up or after-care specialty clinics.
- f. Physical medicine and rehabilitation.
- g. Alcoholism and substance abuse.
- h. Eating disorders.
- i. Cardiac rehabilitation.
- j. Mental health.
- k. Pain management.
- l. Diabetic education.
- m. Pulmonary rehabilitation.
- n. Nutritional counseling for persons aged 20 and under.

78.31(2) Requirements for all outpatient services.

a. *Need for service.* It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. *Professional direction.* All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. *Goals and objectives.* The goals and objectives of the program must be clearly stated. Paragraphs “d” and “f” and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. *Treatment modalities used.* The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. *Criteria for selection and continuing treatment of patients.* The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. *Length of program.* There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. *Monitoring of services.* The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

h. Vaccines. In order to be paid for the outpatient administration of a vaccine covered under the Vaccines for Children (VFC) Program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.31(3) Application for certification. Hospital outpatient programs listed in subrule 78.31(1), paragraphs “g” to “m,” must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) Requirements for specific types of service.

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient’s dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa or bulimia nervosa. Compulsive overeaters are not approved for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia nervosa as established by the current version of the DSM (Diagnostic and Statistical Manual of Mental Disorders) published by the American Psychiatric Association.

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational

or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, mallery-weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

Ear, nose, and throat factors including headaches or dizziness.

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs shall be documented.

The patient's participation in the development of the treatment plans is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance abuse patients in subrule 78.31(3), paragraph "a," subparagraph (6).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac dysrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.

A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

Referral form.

Physician's orders.

Laboratory reports.

Electrocardiogram reports.

History and physical examination.

Angiogram report, if applicable.

Operative report, if applicable.

Preadmission interview.

Exercise prescription.

Rehabilitation plan, including participant's goals.

Documentation for exercise sessions and progress notes.

Nurse's progress reports.

Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, dysrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of mental health problems.

The patient's educational level, vocational status, and job performance history.

The patient's social support network, including family and peer relationship.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational or vocational interests and hobbies.

The patient's ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient's written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.

Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs

are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge. A complete diabetic education program is payable once in the lifetime of a recipient.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

A diagnostic workup which entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician's order to participate anyway.

Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

Patients are reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations, respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

h. Nutritional counseling. Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a hospital for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.31(5) *Services rendered by advanced registered nurse practitioners certified in family, pediatric, or psychiatric mental health specialties and employed by a hospital.* Rescinded IAB 10/15/03, effective 12/1/03.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and

audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

This rule is intended to implement Iowa Code section 249A.4.

441—78.33(249A) Case management services. Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

1. Members who are 18 years of age or over and have a primary diagnosis of intellectual disability, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).
2. Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children’s mental health waiver.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.34(249A) HCBS health and disability waiver services. Payment will be approved for the following services to members eligible for HCBS health and disability waiver services as established in 441—Chapter 83 and as identified in the member’s service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.34(1) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- c. Meal preparation: planning and preparing balanced meals.

78.34(2) Home health services. Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

a. Components of the service include, but are not limited to:

- (1) Observation and reporting of physical or emotional needs.
- (2) Helping a client with bath, shampoo, or oral hygiene.
- (3) Helping a client with toileting.
- (4) Helping a client in and out of bed and with ambulation.
- (5) Helping a client reestablish activities of daily living.
- (6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.
- (7) Performing incidental household services which are essential to the client’s health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.
- (8) Accompaniment to medical services or transport to and from school.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency’s Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per

day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.34(4) *Nursing care services.* Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

78.34(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.34(6) *Counseling services.* Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7) "f" and the skilled activities listed in paragraph 78.34(7) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

- (1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

- (2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.

- (2) Bathing, shampooing, hygiene, and grooming.

- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.

- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

- (8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT

services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.34(9) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.34(10) Personal emergency response or portable locator system.

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The required components of the system are:

1. An in-home medical communications transceiver.

2. A remote, portable activator.

3. A central monitoring station with backup systems staffed by trained attendants at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.34(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) *Consumer choices option.* The consumer choices option (CCO) provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. The consumer choices option is available to any member receiving the AIDS/HIV, brain injury, elderly, health and disability, intellectual disability, or physical disability waiver programs who has the ability and desire to perform all budget authority tasks identified in paragraph 78.34(13) "g" and employer authority tasks identified in paragraph 78.34(13) "h," or who delegates the budget or employer authority tasks identified in paragraph 78.34(13) "i." Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized

in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS health and disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.
2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.
9. Transportation.

(3) Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(4) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

(5) Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Prevocational services.
4. Basic individual respite care.
5. Specialized medical equipment.
6. Supported community living.
7. Supported employment.
8. Transportation.

(6) Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Specialized medical equipment.
4. Transportation.

(7) The department shall determine an average unit cost for each service listed in subparagraphs 78.34(13) “b”(1) to (6) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(8) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member’s service plan before calculating the value of that service to be included in the individual budget amount.

(9) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent.

(10) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13) “b”(7). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13) “b”(8).

(11) Anticipated costs for home and vehicle modification, assistive devices, and specialized medical equipment are not subject to the average cost in subparagraph 78.34(13) “b”(7) or the utilization adjustment factor in subparagraph 78.34(13) “b”(8). The anticipated costs may include the costs of the financial management services and the independent support broker when the home and vehicle modification, assistive device, or specialized medical equipment is the only service included in the CCO monthly budget and the total cost for the home and vehicle modification, assistive device, or specialized medical equipment, including the cost of the financial management services and the independent support broker, is approved by the Iowa Medicaid enterprise or managed care organization as the least costly option to meet the member’s need. Costs for the home and vehicle modification, assistive device, or specialized medical equipment may be paid to the financial management services provider in a one-time payment. Before becoming part of the CCO monthly budget, all home and vehicle modifications, assistive device, and specialized medical equipment shall be identified in the member’s service plan and authorized by the case manager or community-based case manager.

(12) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member’s home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member’s service plan developed by the member’s case manager or community-based case manager.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member’s service plan developed by the member’s case manager or community-based case manager.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member’s service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.

3. Be accommodated within the member's budget without compromising the member's health and safety.

4. Be provided to the member or directed exclusively toward the benefit of the member.

5. Be the least costly to meet the member's needs.

6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13) "d." At a minimum, the CCO monthly budget must include the purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services needed to meet the amount of service authorized for use in CCO identified in the member's service plan. After funds have been budgeted to meet the identified needs, remaining funds from the monthly budget amount may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services as allowed by the monthly budget. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services may exceed the amount of service or supports authorized in the member's service plan. Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.

2. Clothing not related to an assessed medical need.

3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.

4. Costs associated with shipping items to the member.

5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.

7. Home furnishings.

8. Home repairs or home maintenance.

9. Homeopathic treatments.

10. Insurance premiums or copayments.

11. Items purchased on installment payments.

12. Motorized vehicles.

13. Nutritional supplements.

14. Personal entertainment items.

15. Repairs and maintenance of motor vehicles.

16. Room and board, including rent or mortgage payments.

17. School tuition.

18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

23. Services provided in the family home by a parent, stepparent, legal representative, sibling, or stepsibling during overnight sleeping hours unless the parent, stepparent, legal representative, sibling, or stepsibling is awake and actively providing direct services as authorized in the member's service plan.

24. Residential services provided to three or more members living in the same residential setting.

(4) The costs of any approved home or vehicle modification, assistive device, or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification, an assistive device, or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications, assistive devices, and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or community-based case manager. The authorized amount shall not be used for anything other than the specific modification, assistive device, or specialized medical equipment, as identified in subparagraph 78.34(13) "b" (11).

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13) "d." The savings plan shall meet the requirements in paragraph 78.34(13) "f."

f. Savings plan. A member savings plan must be in writing and be approved before the start of the savings plan by the department for fee-for-service members or by the member's managed care organization for members in managed care. Budget amounts allocated to the savings plan must result from efficiencies in meeting the member's service needs identified in the member's service plan.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

5. Specific time spans for accumulating the savings allocation, not to exceed the member's current service plan year end date.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services or supports that were not received. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds allocated to a savings plan may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services included in the monthly budget may exceed the amount of service or supports authorized in the member's service plan. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or community-based case manager.

(4) All funds allocated to a savings plan to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services must be used during the member's waiver year in which the saving occurred.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department or managed care organization to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates for employees shall be consistent with employee reimbursement rates or the prevailing wages paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services. A contingency plan must be established in the member's service plan to ensure service delivery in the event the member's employee is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget. When the member's guardian or legal representative is a paid employee, payment authorization for optional service components must be delegated to a representative pursuant to paragraph 78.34(13) "i."

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the CCO. A common-law employer has the right to direct and control the performance of the services. If the member is a child, the parent or the legal representative shall be responsible for completing all employer authority tasks. Adult members who do not have the ability to complete all employer authority tasks shall have a representative delegated to complete the employer authority tasks identified in this paragraph. Documentation of the person responsible for the employer authority tasks, whether the member or another entity, shall be included in the member's service plan. The member or the delegated employer authority may perform the following functions:

- (1) Recruit and hire employees.
- (2) Verify employee qualifications.
- (3) Specify additional employee qualifications.
- (4) Determine employee duties.
- (5) Determine employee wages and benefits.
- (6) Schedule employees.
- (7) Train and supervise employees.

i. Delegation of budget and employer authority. The member may delegate responsibilities for the individual budget or employer authority functions to a representative. If the member is a child, the parent or the legal representative shall be delegated all budget and employer authority tasks. Adult members aged 18 and older who do not have the ability to complete all budget or employer authority tasks shall have a representative delegated to complete the applicable budget authority tasks identified in paragraph 78.34(13) "g" and employer authority tasks identified in paragraph 78.34(13) "h." Documentation of the person responsible for the budget and employer authority tasks, whether the member or a representative, shall be included in the member's service plan.

- (1) The representative must be at least 18 years old.
- (2) The representative shall not be a current provider of service to the member.
- (3) The member shall sign a consent form that designates who the member has chosen as a representative and the responsibilities of the representative.
- (4) The representative shall not be paid for this service.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have, at a minimum, quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Monitor and track the approved individual budget amount authorized each month and document all expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

(18) The department may request that the financial management service provider withhold payment to any member or member's employee to offset any overpayment or enforce any sanction placed on the service provider pursuant to rule 441—79.3(249A).

m. Responsibilities of the member and the employee. A member participating in the CCO and the member's employee(s) are responsible for the following:

(1) A member participating in the CCO shall be jointly and severally liable with any of the member's employees for any overpayment of medical assistance funds used through a CCO budget.

(2) A member may not employ any person who has been sanctioned, or who is affiliated with a person or an entity that has been sanctioned, under 441—Chapter 79. For purposes of this subparagraph, "sanction" also includes anyone who has been temporarily suspended for a credible allegation of fraud under 42 CFR Part 455. Any CCO funds paid to any employee who or which has been sanctioned is an overpayment that the department shall recoup under 441—Chapter 79.

(3) A member may not employ any person who has been excluded by the Office of the Inspector General of the Department of Health and Human Services under Sections 1128 or 1156 of the Social Security Act and is not eligible to receive federal funds.

(4) Employees shall complete, sign and date Form 470-4429, Consumer Choices Option Semi-Monthly Time Sheet, for each date of service provided to a member. Documentation shall comport with 441—subparagraph 79.3(2) "c"(3), "Service documentation."

(5) Members shall sign, and certify under penalty of perjury, each employee timecard identified in subparagraph 78.34(13) "m"(4) prior to the timecard's submission to the financial management service provider for payment in order to verify that all information on the submitted timecard accurately describes the amount, duration, and scope of services provided. When timecard information is submitted to the financial management service provider in an electronic format, the member shall retain the signed employee timecard for five years from the date of service.

78.34(14) General service standards. All health and disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 5305C, IAB 12/2/20, effective 2/1/21]

441—78.35(249A) Occupational therapist services. Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4.

441—78.36(249A) Hospice services.

78.36(1) General characteristics. A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

- (1) Nursing care.
- (2) Medical social services.
- (3) Physician services.
- (4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.
- (5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.
- (6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.
- (7) Homemaker and home health aide services.
- (8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.
- (9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the

medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) *Approval for hospice benefits.* Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. *Physician certification process.* The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. Election procedures. Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, or a Medicare election of hospice benefit form, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.
4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3553C, IAB 1/3/18, effective 2/7/18]

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to members eligible for the HCBS elderly waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.37(1) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.37(2) Personal emergency response or portable locator system.

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.37(3) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

- a.* Observation and reporting of physical or emotional needs.
- b.* Helping a client with bath, shampoo, or oral hygiene.
- c.* Helping a client with toileting.
- d.* Helping a client in and out of bed and with ambulation.
- e.* Helping a client reestablish activities of daily living.
- f.* Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g.* Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.37(5) Nursing care services. Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin

care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient's condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.37(7) Chore services. Chore services provide assistance with the household maintenance activities listed in paragraph 78.37(7) "a," as necessary to allow a member to remain in the member's own home safely and independently. A unit of service is 15 minutes.

a. Chore services are limited to the following services:

(1) Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows;

(2) Minor repairs to walls, floors, stairs, railings and handles;

(3) Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal;

(4) Lawn mowing and removal of snow and ice from sidewalks and driveways.

b. Leaf raking, bush and tree trimming, trash burning, stick removal, and tree removal are not covered services.

78.37(8) Home-delivered meals. Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals

exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.37(9) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.37(10) *Mental health outreach.* Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

78.37(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.37(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) *Assistive devices.* Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

a. The service shall be included in the member's service plan and shall exceed the services available under the Medicaid state plan.

b. The service shall be provided following prior approval by the Iowa Medicaid enterprise.

c. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.37(14) *Senior companion.* Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

78.37(15) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.37(15)“*f*” and the skilled activities listed in paragraph 78.37(15)“*g*.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual, agency or assisted living facility that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Assisted living agreements with Iowa Medicaid members must specify the services to be considered covered under the assisted living occupancy agreement and those CDAC services to be covered under the elderly waiver. The funding stream for each service must be identified.

(3) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care individual and agency providers must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Assisted living facilities may choose to use Form 470-4389 or may devise another system that adheres to the requirements of rule 441—79.3(249A). Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual, agency or assisted living facility. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member’s home.

(6) Housekeeping, laundry, and shopping essential to the member’s health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.37(16) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.37(17) Case management services. Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

78.37(18) Assisted living service. The assisted living service includes unanticipated and unscheduled personal care and supportive services that are furnished to waiver participants who reside in a homelike, noninstitutional setting. The service includes the 24-hour on-site response capability to meet unpredictable member needs as well as member safety and security through incidental supervision. Assisted living service is not reimbursable if performed at the same time as any service included in an approved consumer-directed attendant care (CDAC) agreement.

- a. A unit of service is one day.
- b. A day of assisted living service is billable only if both the following requirements are met:
 - (1) The member was present in the facility during that day's bed census.
 - (2) The assisted living provider has documented at least one assisted living service encounter for that day, in accordance with rule 441—79.3(249A). The documentation must include the member's response to the service. The documented assisted living service cannot also be an authorized CDAC service.

78.37(19) General service standards. All elderly waiver services must be provided in accordance with the following standards:

- a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:
 - (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
 - (2) The need for the restriction.
 - (3) The less intrusive methods of meeting the need that have been tried but did not work.
 - (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
 - (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
 - (6) The informed consent of the member.
 - (7) An assurance that the interventions and supports will cause no harm to the member.
 - (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.
- d. Services must be billed in whole units.
- e. For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
 - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
 - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2340C, IAB 1/6/16, effective 2/10/16; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 4897C, IAB 2/12/20, effective 3/18/20]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and

work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.38(1) *Counseling services.* Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care, and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

- a. Observation and reporting of physical or emotional needs.
- b. Helping a client with bath, shampoo, or oral hygiene.
- c. Helping a client with toileting.
- d. Helping a client in and out of bed and with ambulation.
- e. Helping a client reestablish activities of daily living.
- f. Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) *Homemaker services.* Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- c. Meal preparation: planning and preparing balanced meals.

78.38(4) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

- a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.38(6) Home-delivered meals. Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.38(7) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.38(8) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.38(8) "f" and the skilled activities listed in paragraph 78.38(8) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.38(9) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.38(10) General service standards. All AIDS/HIV waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter]

441—78.39(249A) Federally qualified health centers. Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

78.39(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.39(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.39(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a federally qualified health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.40(249A) Advanced registered nurse practitioners. Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) Direct payment. Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) Location of service. Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.40(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, an advanced registered nurse practitioner must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.40(5) Prenatal risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.41(1) Supported community living services. Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and

prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect costs associated with members' specific support needs as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.41(1)“f”(1) does not apply.

g. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 20,440 15-minute units are available per state fiscal year except a leap year when 20,496 15-minute units are available.

h. The service shall be identified in the member's service plan.

i. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

78.41(2) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be simultaneously reimbursed with other residential, supported community living, nursing, or home health aide services provided through the medical assistance program.

i. Payment for respite services shall not exceed \$7,334.62 per the member's waiver year.

78.41(3) Personal emergency response or portable locator system.

a. The personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of the system are:

1. An in-home medical communications transceiver.

2. A remote, portable activator.

3. A central monitoring station with backup systems staffed by trained attendants at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

- (1) The required components of the portable locator system are:
 1. A portable communications transceiver or transmitter to be worn or carried by the member.
 2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
- (2) The service shall be identified in the member's service plan.
- (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.
- (4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.41(4) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.41(5) *Nursing services.* Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) *Home health aide services.* Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the member's service plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) *Supported employment services.* Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.41(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.41(8) "f" and the skilled activities listed in paragraph 78.41(8) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
 - (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
 - (8) Colostomy care.
 - (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
 - (10) Postsurgical nursing care.
 - (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
 - (12) Preparing and monitoring response to therapeutic diets.
 - (13) Recording and reporting of changes in vital signs to the nurse or therapist.
- h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):
- (1) Any activity related to supervising a member. Only direct services are billable.
 - (2) Any activity that the member is able to perform.
 - (3) Costs of food.
 - (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
 - (5) Exercise that does not require skilled services.
 - (6) Parenting or child care for or on behalf of the member.
 - (7) Reminders and cueing.
 - (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
 - (9) Transportation costs.
 - (10) Wait times for any activity.

78.41(9) Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
 - (2) During a search for employment by a usual caregiver,
 - (3) To allow for academic or vocational training of a usual caregiver,
 - (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
 - (5) Due to the death of a usual caregiver.
- b. Service requirements.* Interim medical monitoring and treatment services shall:
- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
 - (2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.41(10) *Residential-based supported community living services.* Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)“*d.*”

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed when HCBS intellectual disability waiver daily supported community living service is authorized in a member's service plan.

78.41(12) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), or a full day (4.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.41(13) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.41(14) *Day habilitation.* Day habilitation services will be provided pursuant to subrule 78.27(8).

78.41(15) *Consumer choices option.* The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.41(16) *General service standards.* All intellectual disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3481C, IAB 12/6/17, effective 12/1/17; ARC 3790C, IAB 5/9/18, effective 6/13/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5307C, IAB 12/2/20, effective 2/1/21]

441—78.42(249A) Pharmacists providing covered vaccines. When the authorized pharmacist providing the vaccine meets all Iowa board of pharmacy expanded practice standards and Medicaid requirements, payment will be made for the following:

78.42(1) Vaccines administered to children. Payment will be made to an enrolled provider for an administration fee for vaccines available through the Vaccines for Children (VFC) program administered by the department of public health if the provider is enrolled in the VFC program. Payment will be made for the vaccine cost only if the VFC program stock has been depleted.

78.42(2) Vaccines administered to adults. Payment will be made to an enrolled provider for an administration fee and vaccine cost.

78.42(3) Verification and reporting. Prior to the ordering and administration of an immunization pursuant to statewide protocol, the authorized pharmacist shall consult and review the Iowa Immunization Registry Information System (IRIS) or Iowa Health Information Network (IHIN). Within 30 calendar days following administration of any vaccine, the pharmacist shall report such administration to the patient's primary health care provider, primary physician, and IRIS or IHIN. If a patient does not have a primary health care provider, the pharmacist shall provide the patient with a written record of the vaccine administered to the patient and shall advise the patient to consult a physician.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 5175C, IAB 9/9/20, effective 6/1/21]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.43(1) Case management services. Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. Members who are eligible for targeted case management are not eligible for case management as a waiver service.

78.43(2) Supported community living services. Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.43(2) "e"(1) does not apply.

f. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 33,580 15-minute units per state fiscal year except a leap year, when 33,672 15-minute units are available.

g. The service shall be identified in the member's service plan.

h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

78.43(3) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, supported community living services, nursing, or home health aide services provided through the medical assistance program.

78.43(4) Supported employment services. Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.43(5) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.43(6) Personal emergency response or portable locator system.

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.43(7) Transportation. Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.43(8) Specialized medical equipment.

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:

- (1) Provide for health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.
- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,366.64 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.43(9) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.43(12) *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

- a. A complete assessment of both appropriate and maladaptive behaviors.
- b. Development of a structured behavioral intervention plan which should be identified in the ITP.
- c. Implementation of the behavioral intervention plan.
- d. Ongoing training and supervision to caregivers and behavioral aides.
- e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(13) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.43(13) "f" and the skilled activities listed in paragraph 78.43(13) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.43(14) Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical

intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.
- (4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.
- (5) The member-to-staff ratio shall not be more than six members to one staff person.
- (6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.43(15) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.43(16) General service standards. All brain injury waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
- (2) The need for the restriction.
- (3) The less intrusive methods of meeting the need that have been tried but did not work.
- (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

- (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
- (6) The informed consent of the member.
- (7) An assurance that the interventions and supports will cause no harm to the member.
- (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.
- d.* Services must be billed in whole units.
- e.* For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
 - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
 - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2050C**, IAB 7/8/15, effective 7/1/15; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3874C**, IAB 7/4/18, effective 8/8/18; **ARC 4430C**, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; **ARC 4897C**, IAB 2/12/20, effective 3/18/20; **ARC 5305C**, IAB 12/2/20, effective 2/1/21]

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

This rule is intended to implement Iowa Code section 249A.4.

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

78.45(1) Applicability. ACT services may be provided only to a member who meets all of the following criteria:

- a.* The member is at least 17 years old.
- b.* The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:
 - (1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;
 - (2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and
 - (3) The member exhibits significant impairment in social, interpersonal, or familial functioning.
- c.* The member has a validated principal mental health diagnosis consistent with a severe and persistent mental illness. For this purpose, a mental health diagnosis means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental

Disorders published by the American Psychiatric Association, excluding neurodevelopmental disorders, substance-related disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention. Members with a primary diagnosis of substance-related disorder, developmental disability, or organic disorder are not eligible for ACT services.

d. The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

(1) Is medically stable;

(2) Does not require a level of care that includes more intensive medical monitoring;

(3) Presents a low risk to self, others, or property, with treatment and support; and

(4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

(1) Treatment objectives and outcomes,

(2) The expected frequency and duration of each service,

(3) The location where the services will be provided,

(4) A crisis plan, and

(5) The schedule for updates of the treatment plan.

78.45(2) Services. The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. Evaluation and medication management.

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. Integrated therapy and counseling for mental health and substance abuse. This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. Skill teaching. Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

d. Community support. Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced

registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. Medication monitoring. Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

(1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and

(2) Ensuring that the member keeps appointments.

f. Case management for treatment and service plan coordination. Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the member in gaining access to necessary medical, social, educational, and other services.

3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.

2. Make referrals to services and related activities to assist the member with the assessed needs.

3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.

4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

g. Crisis response. Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

h. Work-related services. Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

(1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.

(2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.

(3) Providing supports to maintain employment, such as crisis intervention related to employment.

(4) Teaching communication, problem solving, and safety skills.

(5) Teaching personal skills such as time management and appropriate grooming for employment.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 1850C, IAB 2/4/15, effective 4/1/15; ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and

work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.46(1) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.46(1) “f” and the skilled activities listed in paragraph 78.46(1) “g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

- (1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

- (2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may

be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.46(2) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.46(3) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.46(4) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:

- (1) Provide for the health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.
- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,366.64 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service.

d. The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.46(5) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.46(6) *Consumer choices option.* The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.46(7) *General service standards.* All physical disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter]

441—78.47(249A) *Pharmaceutical case management services.* Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) *Medicaid recipient eligibility.* Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states

of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) Provider eligibility. Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) Services. Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. Initial assessment. The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:

1. Medication history;

2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;

3. Assessment for the presence of untreated illness; and

4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. New problem assessments. These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. Problem follow-up assessments. These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. Preventive follow-up assessments. These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 9.

441—78.48(249A) Public health agencies. Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0358C, IAB 10/3/12, effective 11/7/12]

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

78.49(1) Covered services. Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) Case management services. Payment shall also be approved for infant and toddler case management services subject to the following requirements:

a. Definition. "Case management" means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child's planned discharge if the child's stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child's planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management

responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child's service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

- (1) Taking the child's history;
- (2) Identifying the needs of the child;
- (3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;
- (4) Completing documentation of the information gathered and the assessment results; and
- (5) Repeating the assessment every six months to determine whether the child's needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

- (1) Include the child's strengths and preferences;
- (2) Consider the child's physical and social environment;
- (3) Specify goals of providing services to the child; and
- (4) Specify actions to address the child's medical, social, educational, and other service needs. These actions may include activities such as ensuring the active participation of the child and working with the child or the child's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. Other service components. Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.

2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.

3. Making referrals to providers for needed services.

4. Scheduling appointments for the child.

5. Facilitating the timely delivery of services.

6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.

2. Whether the services in the plan of care are adequate to meet the needs of the child.

3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

f. Documentation of case management. For each child receiving case management, case records must document:

- (1) The name of the child;
- (2) The dates of case management services;
- (3) The agency chosen by the family to provide the case management services;
- (4) The nature, content, and units of case management services received;
- (5) Whether the goals specified in the care plan have been achieved;
- (6) Whether the family has declined services in the care plan;
- (7) Time lines for providing services and reassessment; and
- (8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) *Child's eligibility.* Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) *Delivery of services.* Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

- a.* Rescinded IAB 5/10/06, effective 7/1/06.
- b.* The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.
- c.* The infant and toddler program provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

This rule is intended to implement Iowa Code section 249A.4.

441—78.50(249A) Local education agency services. Subject to the following subrules, payment shall be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

78.50(1) *Covered services.* Covered services include, but are not limited to, audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

a. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a local education agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

b. Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed \$25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act, payment for transportation between home and school is not a covered service.

78.50(2) *Coordination services.* Rescinded IAB 12/3/08, effective 2/1/09.

78.50(3) *Delivery of services.* Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(4) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

- a.* Rescinded IAB 5/10/06, effective 7/1/06.
- b.* The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.51(249A) Indian health service 638 facility services. Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

This rule is intended to implement Iowa Code section 249A.4.

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to members eligible for the HCBS children's mental health waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.52(1) General service standards. All children's mental health waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

78.52(2) Environmental modifications and adaptive devices.

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

- (1) Items ordinarily covered by Medicaid.
- (2) Items funded by educational or vocational rehabilitation programs.
- (3) Items provided by voluntary means.
- (4) Repair and maintenance of items purchased through the waiver.
- (5) Fencing.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

d. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.52(3) Family and community support services. Family and community support services shall support the member and the member's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the member's and the family's social and emotional strength.

a. Dependent on the needs of the member and the member's family members individually or collectively, family and community support services may be provided to the member, to the member's family members, or to the member and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member's interdisciplinary team pursuant to 441—Chapter 83.

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

- (1) Developing and maintaining a crisis support network for the member and for the member's family.
- (2) Modeling and coaching effective coping strategies for the member's family members.
- (3) Building resilience to the stigma of serious emotional disturbance for the member and the family.
- (4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.
- (5) Modeling and coaching the strategies and interventions identified in the member's crisis intervention plan as defined in 441—24.1(225C) for life situations with the member's family and in the community.
- (6) Developing medication management skills.
- (7) Developing personal hygiene and grooming skills that contribute to the member's positive self-image.
- (8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed \$1500 per member per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must have identified the transportation or therapeutic resource as a support need and included that need in the case manager's plan.

(2) The annual amount available for transportation and therapeutic resources must be listed in the member's service plan.

(3) The member's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member's family or legal guardian.

(4) The member's Medicaid case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

e. The following components are specifically excluded from family and community support services:

- (1) Vocational services.
- (2) Prevocational services.
- (3) Supported employment services.
- (4) Room and board.
- (5) Academic services.
- (6) General supervision and care.

f. A unit of family and community support services is 15 minutes.

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through Medicaid or other funding sources.

c. A unit of in-home family therapy service is 15 minutes.

78.52(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Respite services provided outside the member's home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[**ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 3874C**, IAB 7/4/18, effective 8/8/18; **ARC 5305C**, IAB 12/2/20, effective 2/1/21]

441—78.53(249A) Health home services. Subject to federal approval in the Medicaid state plan, payment shall be made for health home services as described in subrule 78.53(1) provided to an eligible Medicaid member as described in subrule 78.53(2) who has selected a health home services provider as provided in subrule 78.53(3).

78.53(1) *Covered services.* Health home services consist of the following services provided in a comprehensive, timely, and high-quality manner using health information technology to link services, as feasible and appropriate:

- a. Comprehensive care management, which means:

(1) Providing for all the member's health care needs or taking responsibility for arranging care with other qualified professionals;

(2) Developing and maintaining for each member a continuity of care document that details all important aspects of the member's medical needs, treatment plan, and medication list; and

(3) Implementing a formal screening tool to assess behavioral health treatment needs and physical health care needs.

b. Care coordination, which means assisting members with:

(1) Medication adherence;

(2) Chronic disease management;

(3) Appointments, referral scheduling, and reminders; and

(4) Understanding health insurance coverage.

c. Health promotion, which means coordinating or providing behavior modification interventions aimed at:

(1) Supporting health management;

(2) Improving disease control; and

(3) Enhancing safety, disease prevention, and an overall healthy lifestyle.

d. Comprehensive transitional care following a member's move from an inpatient setting to another setting. Comprehensive transitional care includes:

(1) Updates of the member's continuity of care document and case plan to reflect the member's short-term and long-term care coordination needs; and

(2) Personal follow-up with the member regarding all needed follow-up after the transition.

e. Member and family support (including authorized representatives). This support may include:

(1) Communicating with and advocating for the member or family for the assessment of care decisions;

(2) Assisting with obtaining and adhering to medications and other prescribed treatments;

(3) Increasing health literacy and self-management skills; and

(4) Assessing the member's physical and social environment so that the plan of care incorporates needs, strengths, preferences, and risk factors.

f. Referral to community and social support services available in the community.

78.53(2) *Members eligible for health home services.*

a. Subject to the authority of the Secretary of the United States Department of Health and Human Services pursuant to 42 U.S.C. §1396w-4(h)(1)(B) to establish higher levels for the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services, payment shall be made only for health home services provided to a Medicaid member who:

(1) Has at least two chronic conditions;

(2) Has one chronic condition and is at risk of having a second chronic condition;

(3) Has a serious mental illness; or

(4) Has a serious emotional disturbance.

b. For purposes of this rule, the term "chronic condition" means:

(1) A mental health disorder.

(2) A substance use disorder.

(3) Asthma.

(4) Diabetes.

(5) Heart disease.

(6) Being overweight, as evidenced by:

1. Having a body mass index (BMI) over 25 for an adult, or

2. Weighing over the 85th percentile for the pediatric population.

(7) Hypertension.

c. For purposes of this rule, the term "serious mental illness" means:

(1) A psychotic disorder;

(2) Schizophrenia;

(3) Schizoaffective disorder;

- (4) Major depression;
- (5) Bipolar disorder;
- (6) Delusional disorder; or
- (7) Obsessive-compulsive disorder.

d. For purposes of this rule, the term “serious emotional disturbance” means a diagnosable mental, behavioral, or emotional disorder (not including substance use disorders, learning disorders, or intellectual disorders) that is of sufficient duration to meet diagnostic criteria specified in the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and that results in a functional impairment. For this purpose, the term “functional impairment” means episodic, recurrent, or continuous difficulties that substantially interfere with or limit a person from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and that substantially interfere with or limit the person’s role or functioning in family, school, or community activities, not including difficulties resulting from temporary and expected responses to stressful events in a person’s environment.

78.53(3) Selection of health home services provider. As a condition of payment for health home services, the eligible member receiving the services must have selected the billing provider as the member’s health home, as reported by the provider. A member must select a provider located in the member’s county of residence or in a contiguous county.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0838C, IAB 7/24/13, effective 7/1/13]

441—78.54(249A) Speech-language pathology services. Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158. [ARC 0360C, IAB 10/3/12, effective 12/1/12]

441—78.55(249A) Services rendered via telehealth. An in-person contact between a health care professional and a patient is not required as a prerequisite for payment for otherwise-covered services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services are provided, as well as being in accordance with provisions under rule 653—13.11(147,148,272C). Health care services provided through in-person consultations or through telehealth shall be treated as equivalent services for the purposes of reimbursement.

This rule is intended to implement Iowa Code section 249A.4 and 2015 Iowa Acts, Senate File 505, division V, section 12(23).

[ARC 2166C, IAB 9/30/15, effective 11/4/15]

441—78.56(249A) Community-based neurobehavioral rehabilitation services. Payment will be made for community-based neurobehavioral rehabilitation services that do not duplicate other services covered in this chapter.

78.56(1) Definitions.

“*Assessment*” means the review of the current functioning of the member using the service in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

“*Brain injury*” means a diagnosis in accordance with rule 441—83.81(249A).

“*Health care*” means the services provided by trained and licensed health care professionals to restore or maintain the member’s health.

“*Intermittent community-based neurobehavioral rehabilitation services*” are provided to a Medicaid member on an as-needed basis to support the member and the member’s family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member’s own home and community.

“*Member*” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“*Neurobehavioral rehabilitation*” refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels, by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member’s independence in activities of daily living and ability to live in the member’s home and community.

“*Program*” means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

“*Standardized assessment*” means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member’s individual needs.

78.56(2) Member eligibility. To be eligible to receive community-based neurobehavioral rehabilitation services, a member shall meet the following criteria:

a. *Brain injury diagnosis.* To be eligible for community-based neurobehavioral rehabilitation services, the member must have a brain injury diagnosis as set forth in rule 441—83.81(249A).

b. *Risk factors.* The member has the following post-brain injury risk factors:

(1) The member is exhibiting neurobehavioral symptoms in such frequency or severity that the member has undergone or is currently undergoing treatment more intensive than outpatient care and is currently hospitalized, institutionalized, incarcerated or homeless or is at risk of hospitalization, institutionalization, incarceration or homelessness; or

(2) The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).

c. *Need for assistance.* The member exhibits neurobehavioral symptoms in such frequency, severity or intensity that community-based neurobehavioral rehabilitation is required.

d. *Needs assessment.* The member shall have an assessment of need completed prior to admission. The member shall have the Mayo-Portland Adaptability Inventory (MPAI) assessment completed by a qualified trained assessor. The assessment of need shall document the member’s need for community-based neurobehavioral rehabilitation, and the medical services unit of the Iowa Medicaid enterprise or the member’s managed care organization has determined that the member is in need of specialty neurobehavioral rehabilitation services.

e. *Standards for assessment.* Each member will have had the MPAI assessment completed within the 90 days prior to admission. In addition to the functional assessment, the needs assessment will have been completed and will include the assessment of a member’s individual physical, emotional, cognitive, medical and psychosocial residuals related to the member’s brain injury and must include the following:

(1) Identification of the neurobehavioral needs that put the member at risk, including but not limited to verbal aggression, physical aggression, self-harm, unwanted sexual behavior, cognitive and or behavioral perseveration, wandering or elopement, lack of motivation, lack of initiation or other unwanted social behaviors not otherwise specified.

(2) Identification of triggers of unwanted behaviors and the member’s ability to self-manage the member’s symptoms.

(3) The member’s rehabilitation and medical care history to include medication history and status.

(4) The member’s employment history and the member’s barriers to employment.

(5) The member’s dietary and nutritional needs.

(6) The member’s community accessibility and safety.

(7) The member’s access to transportation.

(8) The member’s history of substance abuse.

(9) The member’s vulnerability to exploitation and history of risk of exploitation.

(10) The member's history and status of relationships, natural supports and socialization.

f. Emergency admission. In the event that emergency admission is required, the assessment shall be completed within ten calendar days of admission.

78.56(3) Covered services.

a. Service setting.

(1) Community-based neurobehavioral residential rehabilitation services are provided to a member living in a three-to-five-bed residential care facility with a specialized license designation issued by the department of inspections and appeals; or

(2) Community-based neurobehavioral intermittent rehabilitation services are provided to a member living in the member's own residence in the community.

No payment shall be made for community-based neurobehavioral rehabilitation when provided in a medical institution such as an intermediate care facility for persons with intellectual disabilities, nursing facility or skilled nursing facility.

b. Community-based neurobehavioral rehabilitation residential services identified in the treatment plan may include:

(1) Prescriptive programming to maintain and advance progress made in rehabilitation;

(2) Modifying or adapting the member's environment to improve overall functioning;

(3) Assistance in obtaining preventative, appropriate and timely medical and dental care;

(4) Compensatory strategies to assist in managing ADLS (activities of daily living);

(5) Assistance with coordinating and obtaining physical, oral, or mental health care and any other professional services necessary to the member's health and well-being;

(6) Behavioral and cognitive programming and supports;

(7) Medication management and consultation with pharmacy;

(8) Health and wellness management including dietary and nutritional programming;

(9) Progressive physical strengthening, fitness and retraining;

(10) Assistance with obtaining and use of assistive technology;

(11) Sobriety support development;

(12) Assistance with the self-identification of antecedent triggers;

(13) Assistance with preparation for transition to less intensive services including accessing the community;

(14) Flexibility in programming to meet individual needs;

(15) Assistance with re-learning coping and compensatory strategies;

(16) Support and assistance in seeking substance abuse and co-occurring disorders services;

(17) Support and assistance with obtaining legal consultation and services;

(18) Assistance with community accessibility and safety;

(19) Assistance with re-learning household maintenance;

(20) Assistance with recreational and leisure skill development;

(21) Assistance with the development and application of self-advocacy skills to navigate the service system;

(22) Opportunities to learn about brain injury and individual needs following brain injury;

(23) Support for carrying out the member's individual goals in the rehabilitation treatment plan;

(24) Assistance with pursuit of education and employment goals;

(25) Protective oversight in the residential setting and community;

(26) Assistance and education to family, providers and other support system interests that are supporting the member receiving neurobehavioral rehabilitation services;

(27) Transitional support and training;

(28) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan;

(29) Promotion of a program structure and support for members served so they can relearn or regain skills for maximum independence, community access, and integration.

c. Community-based neurobehavioral rehabilitation intermittent services identified in the treatment plan may occur in the member's own home with or on behalf of the member and may include:

- (1) Promotion of a program structure and support for members served so they can re-learn or regain skills for maximum community inclusion and access;
- (2) Modifying or adapting the member's environment to improve overall functioning;
- (3) Compensatory strategies to assist in managing ADLS (activities of daily living);
- (4) Behavioral supports;
- (5) Assistance with obtaining and use of assistive technology;
- (6) Assistance with the self-identification of antecedent triggers;
- (7) Flexibility in programming to meet the member's individual needs;
- (8) Assistance with re-learning coping and compensatory strategies;
- (9) Assistance with the development and application of self-advocacy skills to navigate the service system;
- (10) Support for carrying out the member's individual goals in the rehabilitation treatment plan;
- (11) Assistance and education to family, providers and other support system interests that are supporting the member receiving community-based neurobehavioral rehabilitation services;
- (12) Transitional support and training;
- (13) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan.

d. Approval of treatment plan. The community-based neurobehavioral services provider shall submit the proposed plan of care, the results of the member's formal assessment, and medical documentation supporting a brain injury diagnosis to the Iowa Medicaid enterprise (IME) medical services unit for approval before providing the services.

e. Initial treatment plan. Within 30 days of admission, the provider shall submit the member's treatment plan to the IME medical services unit.

- (1) The IME medical services unit will approve the provider's treatment plan if:
 1. The treatment plan conforms to the medical necessity requirements in subrule 78.55(4);
 2. The treatment plan is consistent with the written diagnosis and treatment recommendations made by a licensed medical professional that is a licensed neuropsychologist or neurologist, M.D., or D.O.;
 3. The treatment plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;
 4. The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan; and
 5. The treatment plan does not exceed 180 days in duration.
- (2) A treatment summary detailing the member's response to treatment during the previous approval period must be submitted when approval for subsequent plans is requested.

f. Subsequent plans. The IME medical services unit may approve a subsequent neurobehavioral rehabilitation treatment plan that conforms to the conditions of medical necessity pursuant to subrule 78.56(4) and to the conditions pursuant to subrule 78.56(3).

- g.* Quality review. The IME medical services unit may perform the quality review to evaluate:
- (1) The time elapsed from referral to rehabilitation treatment plan development;
 - (2) The continuity of treatment;
 - (3) The length of stay per member;
 - (4) The affiliation of the medical professional recommending services with the neurobehavioral rehabilitation services provider;
 - (5) Gaps in service;
 - (6) The results achieved;
 - (7) Member and stakeholder satisfaction;
 - (8) The provider's compliance with standards listed in rule 441—77.54(249A).

78.56(4) Medical necessity. Nothing in this rule shall be deemed to exempt coverage of community-based neurobehavioral rehabilitation services from the requirement that services be medically necessary. "Medically necessary" means that the service is:

- a.* Consistent with the diagnosis and treatment of the member's condition;

- b.* Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;
- c.* The least costly type of service that can reasonably meet the medical needs of the member; and
- d.* In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:
 - (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
 - (2) The professional literature regarding best practices in the field.

78.56(5) Documentation standards. Community-based neurobehavioral rehabilitation service providers shall maintain service provision records, financial records, and clinical records in accordance with the provisions of rule 441—79.3(249A).

[ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 4792C, IAB 12/4/19, effective 1/8/20]

441—78.57(249A) Child care medical services. Payments will be made to licensed child care centers that provide medical services in addition to child care. Medically necessary services are provided under a plan of care that is developed by licensed professionals within their scope of practice and authorized by the member's physician. The services include and implement a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, personal care, psychosocial and developmental therapies required by the medically dependent or technologically dependent child served.

78.57(1) Nursing services are services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in a licensed child care center. Nursing services shall be provided according to a written plan of care authorized by a physician. Payment for nursing services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Nursing services include activities that require the expertise of a nurse, such as physical assessment, tracheostomy care, medication administration, and tube feedings.

78.57(2) Personal care services are those services which are provided by an aide but are delegated and supervised by a registered nurse under the direction of the member's physician. Payment for personal care services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Personal care services shall be in accordance with the member's plan of care and authorized by a physician. Personal care services include the activities of daily living, oral hygiene, grooming, toileting, feeding, range of motion and positioning, and training the member in necessary self-help skills, including teaching prosocial skills and reinforcing positive interactions.

78.57(3) Psychosocial services are those services that focus at decreasing or eliminating maladaptive behaviors. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Psychosocial services shall be in accordance with the member's plan of care and authorized by a physician. Psychosocial services include implementing a plan using clinically accepted techniques for decreasing or eliminating maladaptive behaviors. Psychosocial intervention plans must be developed and reviewed by licensed mental health providers.

78.57(4) Developmental therapies are those services which are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member's physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Developmental therapies shall be in accordance with the member's plan of care and authorized by a physician. Developmental therapies include activities based on the individual's needs such as fine motor, gross motor, and receptive expressive language.

78.57(5) "Medically necessary" means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, or threaten to cause or aggravate a disability or chronic illness and is an effective course of treatment for the member requesting a service.

78.57(6) Requirements.

- a.* Nursing, psychosocial, developmental therapies and personal care services shall be ordered in writing.

b. Nursing, psychosocial, developmental therapies and personal care services shall be authorized by the department or the department's designated review agent prior to payment.

c. Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. A treatment plan shall be completed prior to the start of care and at a minimum reviewed every 180 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- (1) Place of service.
- (2) Type of service to be rendered and the treatment modalities being used.
- (3) Frequency of the services.
- (4) Assistance devices to be used.
- (5) Date on which services were initiated.
- (6) Progress of member in response to treatment.
- (7) Medical supplies to be furnished.
- (8) Member's medical condition as reflected by the following information, if applicable:
 1. Dates of prior hospitalization.
 2. Dates of prior surgery.
 3. Date last seen by a primary care provider.
 4. Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
 5. Prognosis.
 6. Functional limitations.
 7. Vital signs reading.
 8. Date of last episode of acute recurrence of illness or symptoms.
 9. Medications.
- (9) Discipline of the person providing the service.
- (10) Certification period.
- (11) Physician's signature and date. The treatment plan must be signed and dated by the physician before the claim for service is submitted for reimbursement.
- (12) Forms 470-4815 and 470-4816 are utilized during the prior authorization review.

78.57(7) Nursing, personal care, and psychosocial services do not include:

- a. Services provided to members aged 21 and older.
- b. Services that require prior authorizations that are provided without regard to the prior authorization process.
- c. Nursing services provided simultaneously with other Medicaid services (e.g., home health aide, physical, occupational, or speech therapy services, etc.).
- d. Services that exceed the services that are approvable under the private duty nursing and personal care program pursuant to subrule 78.9(10).
- e. Transportation services.
- f. Services provided to a member while the member is in institutional care.

This rule is intended to implement Iowa Code chapter 249A.

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

441—78.58(249A) Qualified Medicare beneficiary (QMB) provider services.

78.58(1) Payment. Payment will be made to QMB providers for a QMB-eligible member's coinsurance, copayment, and deductible for Medicare-covered services. The eligible member may be responsible for copayments pursuant to 441—subrule 79.1(13).

78.58(2) Definitions.

“Coinsurance” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Medicare cost sharing*” means the Medicare member’s responsibility for a Medicare-covered service. “Medicare cost sharing” includes coinsurance, copayments, and deductibles.

“*Qualified Medicare beneficiary*” or “*QMB*” means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the individual’s Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

This rule is intended to implement Iowa Code section 249A.4.

[ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—78.59(249A) Health insurance premium payment (HIPP) provider services.

78.59(1) Reimbursement. A HIPP provider may bill the department for the HIPP-eligible member’s out-of-pocket cost-sharing obligations. Reimbursement of claims is limited to in-network coinsurance, copayments, and deductibles of the HIPP-eligible member’s health insurance, paid for through the HIPP program. The HIPP-eligible member may be responsible for a copayment pursuant to 441—subrule 79.1(13).

78.59(2) Definitions.

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Cost sharing*” means the member’s health insurance in-network responsibility for a covered service. “Cost sharing” includes coinsurance, copayments, and deductibles.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Eligible member*” means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department’s HIPP program prescribed under rule 441—75.21(249A).

“*Health insurance premium payment (HIPP) program*” or “*HIPP program*” has the same meaning as provided in rule 441—75.21(249A).

This rule is intended to implement Iowa Code section 249A.4.

[ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—78.60(249A) Crisis response services. Payment will be made to providers (eligible pursuant to rule 441—77.55(249A)) of crisis response services, crisis stabilization community-based services, and crisis stabilization residential services delivered as set forth in 441—Chapter 24, Division II.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 3551C, IAB 1/3/18, effective 2/7/18]

441—78.61(249A) Subacute mental health services. Payment will be made to providers (eligible pursuant to rule 441—77.56(249A)) for the provision of subacute mental health care facility services that meet the standards outlined in 481—Chapter 71.

This rule is intended to implement Iowa Code section 249A.4.

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- [Filed ARC 0065C (Notice ARC 9940B, IAB 12/28/11), IAB 4/4/12, effective 6/1/12]
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- [Filed ARC 0359C (Notice ARC 0193C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
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- [Filed ARC 0631C (Notice ARC 0497C, IAB 12/12/12), IAB 3/6/13, effective 5/1/13]
- [Filed ARC 0632C (Notice ARC 0496C, IAB 12/12/12), IAB 3/6/13, effective 5/1/13]
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- [Filed ARC 0757C (Notice ARC 0615C, IAB 2/20/13), IAB 5/29/13, effective 8/1/13]
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- 1 Two ARCs
- 2 Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.
- 3 Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.
- 4 Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.
- 5 Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.
- 6 Two ARCs
- 7 Two ARCs
- 8 At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.
- 9 Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.
- 10 Two or more ARCs
- 11 July 1, 2009, effective date of amendments to 78.27(2)“d” delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.
- 12 May 11, 2011, effective date of 78.34(5)“d,” 78.38(5)“h,” 78.41(2)“g,” 78.43(3)“d,” and 78.52(5)“a” delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.
- 13 July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.
- 14 March 18, 2020, effective date of **ARC 4899C** [amendments to chs 78, 79] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held March 6, 2020; delay lifted at the meeting held August 11, 2020, except with respect to amendments to 78.2(6). Effective date of amendments to 78.2(6) remains delayed until the adjournment of the 2021 session of the General Assembly.

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF
MEDICAL AND REMEDIAL CARE
[Prior to 7/1/83, Social Services[770] Ch 79]

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

For purposes of this chapter, "managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

79.1(1) Types of reimbursement.

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

- (1) The actual charge made by the provider of service.
- (2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's website at: dhs.iowa.gov/ime/providers/csrp/fee-schedule.

d. Fee for service with cost settlement. Rescinded IAB 10/10/18, effective 12/1/18.

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1) "e"(3).

(1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 4.5 percent.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5) "aa" and 79.1(16) "h."

h. Indian health facilities.

(1) Indian health facilities enrolled pursuant to rule 441—77.45(249A) are paid for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible at the current daily visit rates approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register. For services provided to American Indians or Alaskan natives, Indian health facilities may bill for one visit per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)"), which shall constitute payment in full for all medical services provided on that day, except as follows:

1. For services provided to American Indians and Alaskan natives, Indian health facilities may bill for multiple visits per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)") only if medical services are provided for different diagnoses or if distinctly different medical services from different categories of services are provided for the same diagnoses in different units of the facility. For this purpose, the categories of medical services are vision services; dental services; mental health and addiction services; early and periodic screening, diagnosis, and treatment services for children; other outpatient services; and other inpatient services. A visit is a face-to-face contact between a patient and a health professional at or through the facility.

2. For services provided to American Indians or Alaskan natives, Indian health facilities may also bill for one visit per patient per calendar day for outpatient prescribed drugs provided by the facility (at the "outpatient per visit rate (excluding Medicare)"), which shall constitute payment in full for all outpatient prescribed drugs provided on that day.

(2) Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the reimbursement rate otherwise allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form or through pharmacy point of sale. Claims for nonpharmacy services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) *Basis of reimbursement of specific provider categories.*

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/14 plus 10%. Air ambulance: Fee schedule in effect 6/30/14 plus 10%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/13 plus 1%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	Fee schedule in effect 7/1/19. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Behavioral health intervention	Fee schedule	Fee schedule in effect 7/1/13.
Behavioral health services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Birth centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Child care medical services	Fee schedule	Fee schedule in effect 1/1/16.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community-based neurobehavioral rehabilitation services	Fee schedule, see 79.1(28)	Residential: Limit in effect as of June 30 each year plus CPI-U for the preceding 12-month period ending June 30. Intermittent: \$21.11 per 15-minute unit.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Crisis response services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services.
Crisis stabilization community-based services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services.
Crisis stabilization residential services	Fee schedule	Fee schedule in effect 2/1/18.
Dentists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Drug and alcohol services	Fee schedule	Fee schedule in effect 1/1/16.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/13 plus 1%.
Emergency psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Federally qualified health centers	Retrospective cost-related. See 441—Chapter 73	<ol style="list-style-type: none"> 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 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	<p>For AIDS/HIV, brain injury, elderly, and health and disability waivers: Fee schedule</p> <p>For intellectual disability waiver: Fee schedule for the member’s acuity tier, determined pursuant to 79.1(30)</p>	<p>Effective 7/1/16, for AIDS/HIV, brain injury, elderly, and health and disability waivers: Provider’s rate in effect 6/30/16 plus 1%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/16 rate: Veterans Administration contract rate or \$1.47 per 15-minute unit, \$23.47 per half day, \$46.72 per full day, or \$70.06 per extended day if no Veterans Administration contract.</p> <p>Effective 7/1/17, for intellectual disability waiver: The provider’s rate in effect 6/30/16 plus 1%, converted to a 15-minute or half-day rate. If no 6/30/16 rate, \$1.96 per 15-minute unit or \$31.27 per half day.</p> <p>For daily services, the fee schedule rate published on the department’s website, pursuant to 79.1(1)“c,” for the member’s acuity tier, determined pursuant to 79.1(30).</p>
2. Emergency response system: Personal response system	Fee schedule	Effective 7/1/13, provider’s rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Portable locator system	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: One equipment purchase: \$323.26. Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and health and disability waivers effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1% or maximum Medicaid rate in effect 6/30/16 plus 1%. For intellectual disability waiver effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1% or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to an hourly rate.
4. Homemakers	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$5.20 per 15-minute unit.
5. Nursing care	Fee schedule	For AIDS/HIV, health and disability, elderly and intellectual disability waiver effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$87.99 per visit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, not to exceed \$315.09 per day.
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Home care agency:		
Specialized respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.96 per 15-minute unit, not to exceed \$315.09 per day.
Basic individual respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$4.78 per 15-minute unit, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Nonfacility care:		
Specialized respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.96 per 15-minute unit, not to exceed \$315.09 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Basic individual respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$4.78 per 15-minute unit, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Camps	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Adult day care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed rate for regular adult day care services.
Intermediate care facility for persons with an intellectual disability	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed contractual daily rate.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Foster group care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed contractual daily rate.
7. Chore service	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$4.05 per 15-minute unit.
8. Home-delivered meals	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$8.10 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver effective 7/1/13: \$1,061.11 lifetime maximum. For intellectual disability waiver effective 7/1/13: \$5,305.53 lifetime maximum. For brain injury, health and disability, and physical disability waivers effective 7/1/13: \$6,366.64 per year.
10. Mental health outreach providers	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1,440 units per year.
11. Transportation	Fee schedule	Effective 10/1/13: The provider's nonemergency medical transportation contract rate or, in the absence of a nonemergency medical transportation contract rate, the median nonemergency medical transportation contract rate paid per mile or per trip within the member's DHS region.
12. Nutritional counseling	Fee schedule	Effective 7/1/16 for non-county contract: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.76 per 15-minute unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/13: \$115.62 per unit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
14. Senior companion	Fee schedule	Effective 7/1/16 for non-county contract: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$1.89 per 15-minute unit.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$5.35 per 15-minute unit, not to exceed \$123.85 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$5.35 per 15-minute unit, not to exceed \$123.85 per day.
Individual	Fee agreed upon by member and provider	Effective 7/1/16, \$3.58 per 15-minute unit, not to exceed \$83.36 per day. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
16. Counseling:		
Individual	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.45 per 15-minute unit.
Group	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.44 per 15-minute unit. Rate is divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.
17. Case management	Fee schedule	For brain injury and elderly waivers: Fee schedule in effect 7/1/18.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
18. Supported community living	For brain injury waiver: Retrospectively limited prospective rates. See 79.1(15)	For brain injury waiver effective 7/1/16: \$9.28 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 3.927%.
	For intellectual disability waiver: Fee schedule for the member's acuity tier, determined pursuant to 79.1(30). Retrospectively limited prospective rate for SCL 15-minute unit. See 79.1(15)	For intellectual disability waiver effective 7/1/17: \$9.28 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
19. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect 7/1/16. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
Long-term job coaching	Fee schedule	Fee schedule in effect 7/1/16. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect 7/1/16. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$11.45 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.44 per 15-minute unit.
23. Prevocational services, including career exploration	Fee schedule	Fee schedule in effect 7/1/16.
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 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate.
Child development home or center	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit.
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$9.28 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 3.927%.
25. Residential-based supported community living	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/17: The fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
26. Day habilitation	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/17: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.51 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$9.28 per 15-minute unit.
29. In-home family therapy	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$24.85 per 15-minute unit.
30. Financial management services	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$68.97 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$16.07 per hour.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider	\$26.08 per day.
Health home services provider	Fee schedule based on the member's qualifying health condition(s).	Monthly fee schedule amount.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule. See 79.1(24) "d"	Fee schedule in effect 7/1/18.
2. Home-based habilitation	See 79.1(24) "d"	Effective 7/1/13: \$11.68 per 15-minute unit, not to exceed \$6,083 per month, or \$200 per day.
3. Day habilitation	See 79.1(24) "d"	Effective 7/1/13: \$3.30 per 15-minute unit or \$64.29 per day.
4. Prevocational habilitation Career exploration	Fee schedule	Fee schedule in effect May 4, 2016.
5. Supported employment: Individual supported employment	Fee schedule	Fee schedule in effect May 4, 2016. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Long-term job coaching	Fee schedule	Fee schedule in effect May 4, 2016. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect May 4, 2016. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social services; home health care for maternity patients and children	Fee schedule. See 79.1(26). For members living in a nursing facility, see 441—paragraph 81.6(11)“r.”	Effective 7/1/18: Medicare LUPA rates in effect on 6/30/18 plus a 3% increase.
2. Private-duty nursing and personal cares for members aged 20 or under	Retrospective cost-related. See 79.1(27)	Effective 7/1/13: Actual and allowable cost not to exceed a maximum of 133% of statewide average.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)“d”)
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)“g” and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/13 plus 1%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)“c”	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 6/30/13 plus 1%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health facilities	1. Daily visit rate approved by the U.S. Indian Health Service (IHS) for services provided to American Indian and Alaskan native members. See 79.1(1)“h” 2. Fee schedule for service provided for all other Medicaid members.	1. IHS-approved rate published in the Federal Register as outpatient per visit rate (excluding Medicare). 2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for persons with an intellectual disability	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Local education agency services providers	Fee schedule	Fee schedule.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/13 plus 1%.
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16) “d”(1)“1” and (2)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16) “d”(1)“2” and (2)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16) “f.” The direct care rate component limit under 441—81.6(16) “f”(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16) “f”(1) and (2) is 110% of the patient-day-weighted median.
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	See subrules 441—81.6(4) and 81.6(14) and paragraph 81.6(16) “f.” The direct care rate component limit under 441—81.6(16) “f”(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16) “f”(3) is 110% of the patient-day-weighted median.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
	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.	
Occupational therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Fee schedule in effect 6/30/13 plus 1%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Pharmacist vaccine administration	Physician fee schedule for immunization administration	Fee schedule in effect 6/30/13 plus 1%.
Physical therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Fee schedule in effect 6/30/13 plus 1%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)“a”	Fee schedule in effect 6/30/13 plus 1%.
Anesthesia services	Fee schedule. See 79.1(7)“d”	Fee schedule in effect 7/1/17. See 79.1(7)“d.”
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Qualified primary care services	See 79.1(7)“c”	Rate provided by 79.1(7)“c”
Podiatrists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Prescribed drugs	See 79.1(8)	Amount pursuant to 79.1(8).
Psychiatric medical institutions for children:		
1. Inpatient in non-state-owned facilities	Fee schedule	Effective 7/1/14: non-state-owned facilities provider-specific fee schedule in effect.
2. Inpatient in state-owned facilities	Retrospective cost-related	Effective 8/1/11: 100% of actual and allowable cost.
3. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Psychologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Public health agencies	Fee schedule	Fee schedule rate in effect 6/30/13 plus 1%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Rehabilitation agencies	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Medicaid fee schedule in effect 6/30/13 plus 1%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—Chapter 73	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.
Screening centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Speech-language pathologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
State-operated institutions	Retrospective cost-related	
Subacute mental health facility	Fee schedule	Fee schedule in effect 2/1/18.
Targeted case management providers	Fee schedule	Fee schedule in effect 7/1/18.

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 website. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.

b. Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1)“c”). This payment is made directly to the physician or dentist.

79.1(4) Durable medical equipment, prosthetic devices, medical supply dealers. Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality. Reimbursement over an established Medicaid fee schedule amount may be allowed pursuant to the criteria at 441—paragraph 78.10(5)“n.”

79.1(5) Reimbursement for hospitals.

a. Definitions.

“Adolescent” shall mean a Medicaid patient 17 years or younger.

“Adult” shall mean a Medicaid patient 18 years or older.

“Average daily rate” shall mean the hospital’s final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

“*Base year cost report*” means the hospital’s cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008, except as noted in 79.1(5) “x.” Cost reports shall be reviewed using Medicare’s cost reporting and cost reimbursement principles for those cost reporting periods.

“*Blended base amount*” shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Blended capital costs*” shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Capital costs*” shall mean an add-on to the blended base amount, which shall compensate for Medicaid’s portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital’s base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Case-mix adjusted*” shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Case-mix index*” shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Children’s hospitals*” shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children’s hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and

2. Is a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

"Cost outlier" shall mean cases which have an extraordinarily high cost as established in 79.1(5) "f," so as to be eligible for additional payments above and beyond the initial DRG payment.

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

"Diagnosis-related group (DRG)" shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital's case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share payment" shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

"Disproportionate share percentage" shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5) "y"(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share rate" shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"DRG weight" shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

"Final payment rate" shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's

reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

“*Full DRG transfer*” shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

“*GME/DSH fund apportionment claim set*” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated in July of every third year.

“*GME/DSH fund implementation year*” means 2009.

“*Graduate medical education and disproportionate share fund*” or “*GME/DSH fund*” means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

“*Indirect medical education rate*” shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns’ and residents’ program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“*Inlier*” shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

“*Long stay outlier*” shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5)“f.”

“*Low-income utilization rate*” shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“*Medicaid claim set*” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“*Medicaid inpatient utilization rate*” shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children’s hospitals, including hospitals qualifying for disproportionate share as a children’s hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

“Neonatal intensive care unit” shall mean a designated level II or level III neonatal unit.

“Net discharges” shall mean total discharges minus transfers and short stay outliers.

“Quality improvement organization” or *“QIO”* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“Rate table listing” shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

“Rebasing” shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

“Rebasing implementation year” means 2008 and every three years thereafter.

“Recalibration” shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

“Short stay day outlier” shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5)*“f.”*

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5)*“r.”* Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5)*“r.”* Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

c. Calculation of Iowa-specific weights and case-mix index. From the Medicaid claim set, the recalibration for rates effective October 1, 2008, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated with Medicaid charge data from the Medicaid claim set using trimmed claims. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.

2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.

3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.

4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.

5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital. The computation shall use only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. Calculation of blended base amount. The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and

2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs, direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to QIO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus \$75,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(5) Inpatient readmissions within 30 days for same condition. Effective for dates of service on or after July 1, 2015, when an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within 30 days for the same condition, any claim for the subsequent inpatient stay shall be combined with the claim for the original inpatient stay and payment shall be under a single DRG for both stays. The readmission policy does not apply to the following:

1. Scheduled readmissions that are part of repetitive or periodic treatments; and
2. Critical access hospitals.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5) "r," and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5) "r," which are paid per diem, as specified in paragraph 79.1(5) "i."

i. Payment for certified physical rehabilitation hospitals and units and psychiatric units. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5) "r" and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5) "r" is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital's base-year cost report pursuant to paragraph 79.1(5) "a." No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5) "j."

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state's fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare's approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital's reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing implementation year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate setting unit by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5) "y" (3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph 79.1(5) "y," for dates of service prior to October 1, 2014. Out-of-state hospitals do not qualify for disproportionate share payments for dates of service on or after October 1, 2014.

(3) Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5) "y."

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph "f."

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)“b”(1), a neonatal intensive care unit under subparagraph 79.1(5)“b”(2), a psychiatric unit under paragraph 79.1(5)“i,” or a physical rehabilitation hospital or unit under paragraph 79.1(5)“i” shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if the unit’s program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5)“b”(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit’s certification as a level II or level III neonatal unit in accordance with recommendations

set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5) “i” if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5) “i” if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

s. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all “participating hospitals” as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

t. Limitations and application of limitations on payment. Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider’s customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital’s fiscal year.

(2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state’s fiscal year.

u. State-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) “y,” payment shall be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is \$26,633,430.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report.

v. *Non-state-owned teaching hospital disproportionate share payment.* In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment shall be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5) "y" and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between the following:

1. The annual amount appropriated to the IowaCare account for distribution to publicly owned acute care teaching hospitals located in a county with a population over 350,000; and

2. The actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise to qualifying hospitals.

w. *Rate adjustments for hospital mergers.* When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

- (1) Advertising.
- (2) Promotional items.
- (3) Feasibility studies.
- (4) Administrative travel and entertainment.

- (5) Dues, subscriptions, or membership costs.
- (6) Contributions made to other organizations.
- (7) Home office costs.
- (8) Public relations items.
- (9) Any patient convenience items.
- (10) Management fees for administrative services.
- (11) Luxury employee benefits (i.e., country club dues).
- (12) Motor vehicles for other than patient care.
- (13) Reorganization costs.

y. *Graduate medical education and disproportionate share fund.* Payment shall be made to hospitals in Iowa qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is \$7,594,294.03. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is \$13,450,285.14. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

1. For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

2. For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

3. For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

4. For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

5. Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

6. Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

7. Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

8. Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is \$6,959,868.59. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments pursuant to paragraph 79.1(5) "u" or 79.1(5) "v" cannot exceed the amount of the federal cap under Public Law 102-234.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age. In addition, the hospital must be a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

A hospital wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audit and rate setting unit within 20 business days of a request by the department:

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5)“a” to “z” are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5)“a” to “z.” Amounts paid before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5)“k.”

ab. Nonpayment for preventable conditions. Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment shall not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code Explanation

Y	The condition was present or developing at the time of the order for inpatient admission.
N	The condition was not present or developing at the time of the order for inpatient admission.
U	Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.
W	Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission.

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)) if the condition was not present or developing at the time of the order for inpatient admission.

ac. Rural hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)“y,” payment shall be made to qualifying Iowa hospitals that elect to participate in rural hospital disproportionate share payments. Interim monthly payments will be made based on the amount of state share that is transferred to the department.

(1) **Qualifying criteria.** A hospital that qualifies for disproportionate share payments pursuant to paragraph 79.1(5)“y” and that is a rural prospective payment hospital not designated as a critical access hospital qualifies for rural hospital disproportionate share payments.

(2) **Source of nonfederal share.** The required nonfederal share shall be funds generated from tax levy collections of the county or city in which the hospital is located, and is subject to the conditions specified in this subparagraph and applicable federal law and regulations.

1. The nonfederal share funds shall be distributed to the department prior to the issuance of any disproportionate share payment to a qualifying hospital.

2. The city or county providing the nonfederal share funds shall annually document and certify that the funds provided as the nonfederal share were generated from tax proceeds, and not from any other source including federal grants or another federal funding source.

3. The applicable federal matching rate for the fiscal year shall apply.

(3) **Amount of payment.** The total amount of disproportionate share payments made pursuant to paragraph 79.1(5)“y” and the rural hospital disproportionate share payments shall not exceed the amount of the state’s allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) **Final disproportionate share adjustment.** Qualifying hospitals shall annually provide a disproportionate share hospital survey within the time frames specified by the department, for the purpose of calculating the hospital-specific disproportionate share limits under Public Law 103-666.

79.1(6) Independent laboratories. The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician’s Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) Physicians.

a. Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician’s Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2)“e” for the guidelines for immunization replacement.

b. Payment reduction for services rendered in facility settings. The fee schedule amount paid to physicians based on paragraph 79.1(7)“a” shall be reduced by an adjustment factor, as determined by the department and published with the Iowa Medicaid fee schedule, to reflect the lower cost of providing physician services in a facility setting, as opposed to the physician’s office. For the purpose of this provision, a “facility” place of service (POS) is defined as any of the following (consistent with “POS” definitions under Medicare, per the Medicare Claims Processing Manual, Chapter 12, Section 20.4.2, revised as of May 2017):

- (1) Telehealth (POS 02).
- (2) Outpatient hospital-off campus (POS 19).
- (3) Inpatient hospital (POS 21).
- (4) Outpatient hospital-on campus (POS 22).
- (5) Emergency room-hospital (POS 23).
- (6) Ambulatory surgical center (POS 24).
- (7) Military treatment center (POS 26).
- (8) Skilled nursing facility (POS 31).
- (9) Hospice-for inpatient care (POS 34).
- (10) Ambulance-land (POS 41).
- (11) Ambulance-air or water (POS 42).
- (12) Inpatient psychiatric facility (POS 51).
- (13) Psychiatric facility-partial hospitalization (POS 52).
- (14) Community mental health center (POS 53).
- (15) Psychiatric residential treatment center (POS 56).

(16) Comprehensive inpatient rehabilitation (POS 61).

c. Payment for primary care services. To the extent required by 42 U.S.C. § 1396a(a)(13)(C), primary care services furnished in calendar year 2013 or 2014 by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (4) and (6) of this paragraph (79.1(7)“c”). Primary care services furnished January 1, 2015, through June 30, 2017, by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (3), (5), and (7) of this paragraph (79.1(7)“c”).

(1) Primary care services eligible for payment pursuant to this paragraph (79.1(7)“c”) include:

1. Evaluation and management (E & M) services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 99201 through 99499, or their successor codes; and

2. Vaccine administration services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes.

(2) For purposes of this paragraph (79.1(7)“c”), a qualified primary care physician is a physician who:

1. Is certified by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA) with a specialty designation of family medicine, general internal medicine, or pediatric medicine or with a subspecialty designation recognized by the certifying organization as a subspecialty of family medicine, general internal medicine, or pediatric medicine; or

2. Has furnished primary care services eligible for payment pursuant to this paragraph (79.1(7)“c”) equal to at least 60 percent of the Iowa Medicaid services for which the qualified primary care physician has submitted claims during the most recently completed calendar year or, for newly eligible physicians, the prior month (excluding claims not paid and claims for which Medicare is the primary payer).

(3) For payment to be made under this paragraph (79.1(7)“c”), the qualified primary care physician must have certified that the physician is a qualified primary care physician by submitting Form 470-5138, Iowa Medicaid Primary Care Physician Certification and Attestation for Primary Care Rate Increase, prior to the date of service or by April 1, 2013, for services rendered January 1, 2013, through April 1, 2013.

(4) Primary care services rendered in calendar year 2013 or 2014. Primary care services rendered in calendar year 2013 or 2014 that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B, in effect for services rendered on the first day of the calendar year;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on the first day of the calendar year, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1).

(5) Primary care services rendered on or after January 1, 2015. Primary care services rendered on or after January 1, 2015, that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B in effect for services rendered on January 1, 2014;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on January 1, 2014, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1), and in effect on June 30, 2014.

(6) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program in calendar year 2013 or 2014 shall be limited to the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program; or

2. The applicable Medicare fee schedule rate for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

(7) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program on or after January 1, 2015, shall be the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program in effect on June 30, 2014; or

2. The applicable Medicare fee schedule rate in effect on June 30, 2014, for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 rate that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

d. Payment for anesthesia services. Anesthesia services are paid pursuant to this paragraph and the Iowa Medicaid fee schedule published by the department pursuant to paragraph 79.1(1)“c.” Anesthesia procedures listed in the fee schedule with a factor code of “F” are paid at the dollar amount of the factor listed for the procedure in the fee schedule. Anesthesia procedures listed in the fee schedule with a factor code of “A” are paid a dollar amount equal to the Iowa Medicaid anesthesia conversion factor multiplied by the sum of the minutes of service provided and the factor listed for the procedure in the fee schedule. Beginning July 1, 2017, the Iowa Medicaid anesthesia conversion factor is the current Medicare anesthesia conversion factor for Iowa, converted to a per-minute amount. For 2017, that amount is \$1.40, which will be updated annually on January 1.

79.1(8) Drugs.

a. Except as provided below in paragraphs 79.1(8)“d” through “h,” all providers are reimbursed for covered drugs as follows:

(1) Reimbursement for covered generic prescription drugs and for covered nonprescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)“b,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c”;

2. The federal upper limit (FUL), defined as the upper limit for a multiple source drug established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514(a)-(c), plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c”;

3. The total submitted charge, represented by the lower of the gross amount due (GAD) as defined by the National Council for Prescription Drug Programs (NCPDP) standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee, determined pursuant to paragraph 79.1(8)“c”; or

4. Providers’ usual and customary charge to the general public.

(2) Reimbursement for covered brand-name prescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state AAC, determined pursuant to paragraph 79.1(8)“b,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c”;

2. The total submitted charge, represented by the lower of the GAD as defined by the NCPDP standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee; or

3. Providers’ usual and customary charge to the general public.

b. For purposes of this subrule, average state AAC is defined as retail pharmacies' average prices paid to acquire drug products. Average state AAC shall be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys shall be conducted at least once every six months, or more often at the department's discretion. The average state AAC shall be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average state AAC determined by the department shall be published on the Iowa Medicaid enterprise website. If no current average state AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span shall be used as the average state AAC.

c. Professional dispensing fee.

(1) For purposes of this subrule, the professional dispensing fee shall be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers' costs of dispensing drugs to Medicaid beneficiaries. The survey shall be conducted every two years beginning in state fiscal year 2014-2015.

(2) There is a one-time professional dispensing fee reimbursed per one-month or three-month period, accounting for the refill tolerance of 90 percent consumption, per member, per drug, per strength, billed per provider for maintenance drugs as identified by MediSpan and maintenance nonprescription drugs.

d. For an oral solid dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist, an additional one cent per dose shall be added to reimbursement based on acquisition cost or FUL. Payment may be made only for unit-dose-packaged drugs that are consumed by the patient. Any previous charges for unused unit-dose packages returned to the pharmacy must be credited to the Medicaid program, consistent with the Iowa board of pharmacy's rules on return of drugs.

e. 340B-purchased drugs.

(1) Notwithstanding paragraph 79.1(8) "a" above, reimbursement to a covered entity as defined in 42 U.S.C. 256b(a)(4) for covered outpatient drugs acquired by the entity through the 340B drug pricing program will be the lowest of:

1. The 340B covered entity actual acquisition cost (not to exceed the 340B ceiling price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

2. The average state AAC determined pursuant to paragraph 79.1(8) "b" plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

3. For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8) "a"(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

4. The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

5. Providers' usual and customary charge to the general public.

(2) Reimbursement for covered outpatient drugs to a 340B contract pharmacy, under contract with a covered entity described in 42 U.S.C. 256b(a)(4), will be according to paragraph 79.1(8) "a" because covered outpatient drugs purchased through the 340B drug pricing program cannot be billed to Medicaid by a 340B contract pharmacy.

f. Federal supply schedule (FSS) drugs. Notwithstanding paragraph 79.1(8) "a" above, reimbursement for drugs acquired by a provider through the FSS program managed by the federal General Services Administration will be the lowest of:

(1) The provider's actual acquisition cost (not to exceed the FSS price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

(2) The average state AAC determined pursuant to paragraph 79.1(8) "b" plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8) "a"(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers' usual and customary charge to the general public.

g. Nominal-price drugs. Notwithstanding paragraph 79.1(8)“a” above, reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug’s “best price” pursuant to 42 CFR 447.508 will be the lowest of:

- (1) The provider’s actual acquisition cost (not to exceed the nominal price paid), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;
- (2) The average state AAC determined pursuant to paragraph 79.1(8)“b” plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;
- (3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)“a”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;
- (4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or
- (5) Providers’ usual and customary charge to the general public.

h. Indian health facilities enrolled pursuant to rule 441—77.45(249A). For all drugs provided to American Indians or Alaskan natives by Indian health facilities enrolled pursuant to rule 441—77.45(249A), reimbursement is one pharmacy encounter payment per date of service, notwithstanding paragraphs 79.1(8)“a” through “f.” The pharmacy encounter rate is the current “outpatient per visit rate (excluding Medicare)” approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register, and includes reimbursement for the dispensing fees, ingredient cost, and any necessary counseling by the pharmacist.

i. Physician-administered drugs. Notwithstanding paragraphs 79.1(8)“a” through “f,” payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II “J” codes, as a physician service, shall be pursuant to the physician payment policy under subrule 79.1(2).

j. Under this subrule, no payment shall be made for sales tax.

l. For purposes of this subrule, the Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic.

79.1(9) *HCBS consumer choices financial management.* Rescinded IAB 5/8/19, effective 7/1/19.

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 of \$1 for each covered prescription or refill of any covered drug.

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 brain injury waiver supported community living; HCBS intellectual disability waiver supported community living for 15-minute services; HCBS family and community support services; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency.

a. Reporting requirements.

(1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to the IME Provider Cost Audits and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, or by electronic mail to costaudit@dhs.state.ia.us, 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 in the brain injury waiver.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

(8) Transportation and therapeutic resources reimbursement shall not exceed \$1,500 per child per year for family and community support services.

(9) The reasonable costs of direct care staff training shall be treated as direct care costs, rather than as indirect administrative costs.

c. Prospective rates for new providers.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph "e."

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph "d."

d. Prospective rates for established providers.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider's new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph "f."

e. Prospective rates for respite. Rescinded IAB 5/1/13, effective 7/1/13.

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) For services provided from July 1, 2015, through June 30, 2016, revenues exceeding adjusted actual costs by more than 4.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) For services provided from July 1, 2015, through June 30, 2016, providers who do not reimburse revenues exceeding 104.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 104.5 percent of the actual costs deducted from future payments.

(4) For services provided on or after July 1, 2016, revenues exceeding adjusted actual costs by more than 5.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(5) For services provided on or after July 1, 2016, providers who do not reimburse revenues exceeding 105.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 105.5 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

79.1(16) Outpatient reimbursement for hospitals.

a. Definitions.

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or *"APC"* means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or *"APC relative weight"* means the relative value assigned to each APC.

"Ancillary service" means a supplemental service that supports the diagnosis or treatment of the patient's condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

"APC service" means a service that is priced and paid using the APC system.

"Base year cost report," for rates effective January 1, 2009, means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008. Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base APC rate" shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

"Cost outlier" shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph "g" and are therefore eligible for additional payments above and beyond the base APC payment.

"Current procedural terminology—fourth edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

“Diagnostic service” means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

“Direct medical education costs” shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

“Direct medical education rate” shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

“Discount factor” means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

“GME/DSH fund apportionment claim set” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

“GME/DSH fund implementation year” means 2009.

“Graduate medical education and disproportionate share fund” or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

“Healthcare common procedures coding system” or *“HCPCS”* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

“Hospital-based clinic” means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

“Medicaid claim set” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“Modifier” means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

“Multiple significant procedure discounting” means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

“Observation services” means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

“Outpatient hospital services” means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

“Outpatient prospective payment system” or *“OPPS”* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare’s outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

“Outpatient visit” shall mean those hospital-based outpatient services which are billed on a single claim form.

“*Packaged service*” means a service that is secondary to other services but is considered an integral part of another service.

“*Pass-through*” means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

“*Quality improvement organization*” or “*QIO*” shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“*Rebasing*” shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

“*Significant procedure*” shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

“*Status indicator*” or “*SI*” means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPSS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPSS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital’s financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member’s condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital’s DRG reimbursement rate for the inpatient services.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPSS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)“c.”

(2) Except as provided in paragraph 79.1(16)“h,” outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPSS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16)“j.”

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)“e.”

2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.

3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPSS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPSS APC or under another payment system and whether particular OPSS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPSS APC and services that are not paid under an OPSS APC.

Indicator	Item, Code, or Service	OPSS Payment Status
A	<p>Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPSS, such as:</p> <ul style="list-style-type: none"> ● 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. 	<p>For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>
B	Codes that are not paid by Medicare on an outpatient hospital basis	<p>Not paid under OPSS APC.</p> <ul style="list-style-type: none"> ● 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	<p>If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC. Admit the patient and bill as inpatient care.</p>
D	Discontinued codes	Not paid under OPSS APC or any other Medicaid payment system.
E	<p>Items, codes, and services:</p> <ul style="list-style-type: none"> ● 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. 	<p>If covered by Iowa Medicaid, the item, code, or service is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item, code, or service is not paid under OPSS APC or any other Medicaid payment system.</p>

Indicator	Item, Code, or Service	OPPS Payment Status
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: <ul style="list-style-type: none"> ● 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.

Indicator	Item, Code, or Service	OPPS Payment Status
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX-packaged codes	Paid under OPPS APC. <ul style="list-style-type: none"> ● 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. <ul style="list-style-type: none"> ● 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.

Indicator	Item, Code, or Service	OPPS Payment Status
V	Clinic or emergency department visit	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)“r.”</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
X	Ancillary services	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
Y	Nonimplantable durable medical equipment	<p>For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital’s base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital’s total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital’s total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital’s base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n.”

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.
2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n,” for all hospitals.
3. The total calculated Medicaid cost for ambulance services for all hospitals.
4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus \$2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital’s cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)“a” shall be the hospital’s line-item charge multiplied by the hospital’s Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital’s annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)“j.”

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

- (1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

- (2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

- (3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

- (1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

- (2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

- (3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

- (4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16) "v"(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs (1) and (2).

- (1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

- (2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16) "v."

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

- (1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

- (2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be implemented until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4)“d”(7) and are reimbursed on a fee schedule basis.

r. Services delivered in the emergency room. Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Payment for treatment of a Medicaid member in an emergency room shall be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room.

1. For members who were referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Government-owned facilities. Rescinded IAB 6/30/10, effective 7/1/10.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

v. Graduate medical education and disproportionate share fund. Payment shall be made to hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is \$2,766,718.25. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

w. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus

3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

79.1(17) Reimbursement for home- and community-based services home and vehicle modification and equipment. Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid enterprise for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member's medical needs.

c. Payment for most items shall be based on a fee schedule and shall conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment shall not exceed 80 percent of the purchase allowance.

(8) No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

79.1(18) Pharmaceutical case management services reimbursement. Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

<u>Service</u>	<u>Payment amount</u>	<u>Number of payments</u>
Initial assessment	\$75	One per patient
New problem assessment	\$40	Two per patient per 12 months
Problem follow-up assessment	\$40	Four per patient per 12 months
Preventative follow-up assessment	\$25	One per patient per 6 months

79.1(19) Reimbursement for translation and interpretation services. Reimbursement for translation and interpretation services shall be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services shall be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee shall be established for translation and interpretation services, which shall be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

79.1(20) Dentists. The dental fee schedule is based on the definitions of dental and surgical procedures given in the current version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association.

79.1(21) Rehabilitation agencies. Subject to the Medicaid upper limit in 79.1(2), payments to rehabilitation agencies shall be made as provided in the areawide fee schedule established for Medicare by the Centers for Medicare and Medicaid Services (CMS). The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) Medicare crossover claims. Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for Medicare crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Medicaid-allowed amount*” means the Medicaid reimbursement for the service(s) rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

“*Medicare-allowed amount*” means the total reimbursement allowed by Medicare for the service(s) rendered, for a participating Medicare provider who has accepted Medicare assignment of claims for services rendered, including any portion to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Medicare cost sharing*” means the Medicare member's responsibility to pay for a Medicare-covered service. “Medicare cost sharing” includes coinsurance, copayments, and deductibles.

“*Medicare crossover claim*” means a claim for Medicaid payment for services covered by Medicare Part A or Part B rendered to a Medicare beneficiary who is also eligible for Medicaid. Medicare 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.

“*Medicare deductible and coinsurance amounts*” means the portion of the Medicare-allowed amount to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Medicare provider reimbursement*” means the Medicare-allowed amount less any portion thereof to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Qualified Medicare beneficiary*” or “*QMB*” means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the individual’s Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

“*Third-party payment*” means payment from any source other than Medicaid, Medicare, or the Medicaid and Medicare beneficiary.

b. Reimbursement of Medicare crossover claims. Covered Medicare crossover claims shall be paid by Medicaid at the lesser of:

(1) Applicable Medicare deductible and coinsurance amounts, less any third-party payment available to the provider for the Medicare deductible and coinsurance amounts and any Medicaid copayment or spenddown; or

(2) Either:

1. For Medicaid-covered services: the Medicaid-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown; or

2. For non-Medicaid-covered services: 50 percent of the Medicare-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown.

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 all home- and community-based habilitation services provided on or after January 1, 2016, shall be as provided in paragraph 79.1(24) "d." All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) A unit of case management is 15 minutes.

(2) A unit of home-based habilitation is a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period as an average over a calendar month. Reimbursement for services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2).

1. The daily unit of service shall be used when a member receives services for 8 or more hours provided during a 24-hour period as an average over a calendar month. The 15-minute unit shall be used when the member receives services for 1 to 31 15-minute units provided during a 24-hour period as an average over a calendar month.

2. The member's comprehensive service plan must identify and reflect the need for the amount of supervision and skills training requested. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

(3) A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

(4) A unit of supported employment habilitation supports to maintain employment is a 15-minute unit.

b. Submission of cost reports. For services provided prior to July 1, 2013, the department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed \$1570 per consumer per year. The provider must maintain records to support all expenditures.

(3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

(4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.

(6) If a provider fails to submit a cost report for services provided through June 30, 2013, that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's rate to 76 percent of the current rate. The reduced rate shall be paid until the provider's cost report has been received by the Iowa Medicaid enterprise's provider cost audit and rate setting unit pursuant to subparagraph 79.1(24) "b"(4) but for not longer than three months, after which time no further payments will be made.

(7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination based on cost reports. For services provided prior to July 1, 2013, reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through an interim rate and the reasonable and proper costs of operation determined in accordance with this subrule.

d. Reimbursement for services provided on or after January 1, 2016.

(1) For dates of services on or after January 1, 2016, habilitation services, except for case management, shall be reimbursed by fee schedule. Case management will continue to be reimbursed by retrospective cost settlement.

(2) For dates of services on or after July 1, 2018, case management services shall be reimbursed by fee schedule.

79.1(25) Reimbursement for community mental health centers (CMHCs) and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).

a. Reimbursement methodology for providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3). Effective for services rendered on or after October 1, 2006, providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles.

b. Reimbursement methodology for community mental health centers. Effective for services rendered on or after July 1, 2014, community mental health centers may elect to be paid on either a 100 percent of reasonable costs basis, as determined by Medicare reimbursement principles, or in accordance with an alternative reimbursement rate methodology approved by the department of human services. Once a community mental health center chooses the alternative reimbursement rate methodology, the community mental health center may not change its elected reimbursement methodology to 100 percent of reasonable costs.

c. Cost-based reimbursement. For providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) and CMHCs that elect the 100 percent of reasonable costs basis of reimbursement, rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report, pursuant to the following.

(1) Until a provider that was enrolled in the Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the Iowa Medicaid enterprise shall make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or
2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the Iowa Medicaid enterprise shall make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that the Iowa Medicaid enterprise will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) The Iowa Medicaid enterprise shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) The Iowa Medicaid enterprise shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

d. Reporting requirements. All providers other than CMHCs that have elected the alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services shall submit cost reports using Form 470-4419, Financial and Statistical Report. Hospital-based providers required to submit a cost report shall also submit the Medicare cost report, CMS Form 2552-96. The following requirements apply to all required cost reports.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate shall be paid for not longer than three months, after which time no further payments will be made.

79.1(26) Home health services.

a. Services included under the home health services program are reimbursed on the low utilization payment amount (LUPA) methodology, with state geographic adjustments.

b. Medicare LUPA per-visit rates in effect on July 1, 2013, are the basis for establishing the LUPA methodology for the initial reimbursement schedule.

c. Medicare LUPA per-visit rates shall be increased July 1 every two years to reflect the most recent Medicare LUPA rates.

d. Home health services subject to this methodology are skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services provided by Medicare-certified home health agencies.

79.1(27) Reimbursement for early periodic screening, diagnosis, and treatment private duty nursing and personal cares program.

a. *Rate determination based on cost reports.* Reimbursement shall be made using an hourly rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation not to exceed the upper limit as provided in subrule 79.1(2).

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated 15-minute and hourly rate. Pending determination of private duty nursing and personal cares program costs, the provider may bill for and shall be reimbursed at an hourly rate that the provider and the Iowa Medicaid enterprise (IME) may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review or audit or both by the Iowa Medicaid enterprise to determine the actual cost of services in accordance with generally accepted accounting principles, Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, and the Office of Management and Budget Circular A-87, Attachment B, subject to the exceptions and limitations in the department's administrative rules.

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through interim rates and the reasonable and proper costs of operation determined in accordance with this subrule.

b. *Financial and statistical report submission and reporting requirements.*

(1) The provider shall submit the complete Financial and Statistical Report, Form 1728-94, in an electronic format approved by the department to the IME provider cost audit and rate setting unit within five months of the end of the provider's fiscal year.

(2) The submission of the financial and statistical report must include a working trial balance that corresponds to the data contained on the financial and statistical report and the Medicare cost report. Financial and statistical reports submitted without a working trial balance and the Medicare cost report will be considered incomplete.

(3) A provider may obtain a 30-day extension for submitting the financial and statistical report by sending a letter to the IME provider cost audit and rate setting unit. The extension request must be received by the IME provider cost audit and rate setting unit before the original due date. No extensions will be granted beyond 30 days.

(4) Providers shall submit a completed financial and statistical report to the IME provider cost audit and rate setting unit in an electronic format that can be opened using the extension xls or xlsx. The supplemental documentation shall be submitted in a generally accepted business format. The report and required supplemental information shall be emailed to costaudit@dhs.state.ia.us on or before the last day of the fifth month after the end of the provider's fiscal year. One signed copy of the certification page of the Medicaid and Medicare cost reports shall be mailed to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, no later than the due date of the required electronic submissions.

(5) If a provider fails to submit a cost report that meets the requirement of subparagraph 79.1(27) "b"(4), the department shall reduce payment to 75 percent of the current rate(s).

1. The reduced rate(s) shall be effective the first day of the sixth month following the provider's fiscal year end and shall remain in effect until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

2. The reduced rate(s) shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

(6) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting and provide documentation detailing these adjustments. Failure to maintain records to support the cost report may result in the following, but not limited to:

1. Recoupment of Medicaid payments.
2. Penalties.
3. Sanctions pursuant to rule 441—79.3(249A).

(7) The department, in its sole discretion, may on its own initiative reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or to submit an amended financial and statistical report for review by the department, after the provider is notified of its reimbursement rates following review of a financial and statistical report.

(8) A projected cost report shall be submitted when a home health agency enters the program or adds private duty nursing and the personal cares program. Prospective interim rates shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new program is added.

(9) A provider of services under multiple programs shall submit a cost allocation schedule that was used during the preparation of the financial and statistical report.

(10) Costs reported under private duty nursing and the personal cares program shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under private duty nursing and the personal cares program.

(11) When a provider continues to include as an item of cost an item or items which had in a prior period been removed by an adjustment by the department or its contractor, in the total program costs, the contractor shall recommend to the department that the reimbursement rates be reduced to 75 percent of the current reimbursement rate for the entire quarter beginning the first day of the sixth month after the provider's fiscal year end. The department may, after considering the seriousness of the exception, make the reduction.

(12) Nothing in this subrule relieves a provider of its obligation to immediately inform the department that it has retained Medicaid funds to which it is not entitled as a result of any cost report process. A provider must notify the Iowa Medicaid enterprise when the provider notes that funds are incorrectly paid or when an overpayment has been detected.

c. Terminated home health agencies.

(1) A participating home health agency contemplating termination of private duty nursing and the personal cares program shall provide the department of human services with at least 60 days' prior notice. The person responsible for the termination is responsible for submission of a final financial and statistical report through the date of the termination. The final home health cost report shall meet the reporting requirements in paragraph 79.1(27) "b."

(2) For facilities that terminate activity with the Iowa Medicaid enterprise, a financial and statistical report from the beginning of the fiscal year to the date of termination will be required, regardless if termination is voluntary, involuntary or due to a change in ownership. All documentation in paragraph 79.1(27) "a" shall be submitted 45 days after the date of termination, by the terminated (closed) entity. If no report is received within 45 days, the Iowa Medicaid enterprise will begin the process to recoup all funds for dates of service beginning from the last filed cost report to the date of termination.

79.1(28) Reimbursement for community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services.

a. New providers. Providers who are newly enrolled shall be paid prospective rates based on projected reasonable and proper costs of operation based on the statewide average rate paid to community-based neurobehavioral rehabilitation service providers in effect June 30 each fiscal year.

b. Established providers. After establishment of the initial rate for a provider, the rate will be adjusted annually, effective July 1 each year. The provider's new rate shall be the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, not to exceed the limit in effect June 30.

79.1(29) *Reimbursement for health insurance premium payment (HIPP) program providers.* Reimbursement for HIPP program providers shall be provided only when such provider is enrolled with Iowa Medicaid for the sole purpose of billing HIPP-eligible in-network coinsurance, copayments, and deductibles.

a. Definitions. For purposes of this subrule:

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Deductible*” means the amount paid for covered health care services before the insurance plan starts to pay.

“*Eligible member*” means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department's HIPP program prescribed under rule 441—75.21(249A).

“*Health insurance premium payment (HIPP) program*” or “*HIPP program*” has the same meaning as provided in rule 441—75.21(249A).

b. Claim submission. To submit a claim for reimbursement, a HIPP provider shall use Form 470-5475, Health Insurance Premium Payment (HIPP) Provider Invoice.

(1) Payment shall be made to eligible providers for a HIPP-eligible member's coinsurance, copayment, and deductible, when the HIPP-eligible member is active on the date of service.

(2) Member responsibility. The eligible member may be responsible for a copayment pursuant to subrule 79.1(13).

79.1(30) *Tiered rates.* For supported community living services, residential-based supported community living services, day habilitation services, and adult day care services provided under the intellectual disability waiver, the fee schedule published by the department pursuant to paragraph 79.1(1) “*c*” provides rates based on the acuity tier of the member, as determined pursuant to this subrule.

a. Acuity tiers are based on the results of the Supports Intensity Scale® (SIS) core standardized assessment. The SIS assessment tool and scoring criteria are available on request from the Iowa Medicaid enterprise, bureau of long-term care.

b. The assignment of members to acuity tiers is based on a mathematically valid process that identifies meaningful differences in the support needs of the members based on the SIS scores.

c. For supported community living daily services paid through a per diem, there are two reimbursement sublevels within each tier based on the number of hours of day services a member receives monthly. Day services include enhanced job search services, supported employment, prevocational services, adult day care, day habilitation and employment outside of Medicaid reimbursable services. The two reimbursement sublevels reflect reimbursement for:

(1) Members who receive an average of 40 hours or more of day services per month.

(2) Members who receive an average of less than 40 hours of day services per month.

d. For this purpose, the “SIS activities score” is the sum total of the subscale raw SIS scores converted to standard scores on the following subsections:

(1) Subsection 2A: Home Living Activities;

(2) Subsection 2B: Community Living Activities;

(3) Subsection 2E: Health and Safety Activities; and

(4) Subsection 2F: Social Activities.

e. Also used in determining a member's acuity tier, as provided in paragraphs 79.1(30) “*f*” and “*g*,” are the subtotal scores on the following subsections:

(1) Subsection 1A: Exceptional Medical Support Needs, excluding questions 16 through 19; and

(2) Subsection 1B: Exceptional Behavioral Support Needs, excluding question 13.

f. Subject to adjustment pursuant to paragraph 79.1(30) “*g*,” acuity tiers are the highest applicable tier pursuant to the following:

- (1) Tier 1: SIS activities score of 0 – 25.
- (2) Tier 2: SIS activities score of 26 – 40.
- (3) Tier 3: SIS activities score of 41 – 44 or SIS activities score of 0 – 40 and a SIS subsection 1B subtotal score of 6 or higher.
- (4) Tier 4: SIS activities score of 45 or higher.
- (5) Tier 5: SIS activities score of 41 or higher and a subsection 1B subtotal score of 7 or higher.
- (6) Tier 6: SIS subsection 1A or 1B subtotal score of 14 or higher.
- (7) RCF tier: Members residing in a residential care facility (RCF) licensed for six or more beds.
- (8) RBSCCL tier: Members residing in a residential-based supported community living (RBSCCL) facility.
- (9) Enhanced tier: An individual member rate negotiated between the department and the provider.
 - g. The tier determined pursuant to paragraph 79.1(30)“f” shall be adjusted as follows:
 - (1) For members with a subsection 1A subtotal score of 2 or 3, as provided in subparagraph 79.1(30)“e”(1), but with a response of “extensive support needed” (score = 2) in response to any prompt in subsection 1A, as provided in subparagraph 79.1(30)“e”(1) and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
 - (2) For members with a subsection 1A subtotal score of 4 – 9, and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
 - (3) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 1 to 3 pursuant to paragraph 79.1(30)“f,” the tier is increased by two tiers.
 - (4) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
 - (5) Any member may receive an enhanced tier rate when approved by the department for fee-for-service members.
 - h. Tier redetermination. A member’s acuity tier may be changed in the following circumstances:
 - (1) There is a change in the member’s SIS activity scores as determined in the annual level of care redetermination process pursuant to rule 441—83.64(249A).
 - (2) A completed DHS Form 470-5486, Emergency Needs Assessment, indicates a change in the member’s support needs. A member’s case manager may request an emergency needs assessment when a significant change in the member’s needs is identified. When a completed emergency needs assessment indicates significant changes that are likely to continue in three of the five domains assessed, a full SIS core standardized assessment shall be conducted and any change in the SIS scores will be used to determine the member’s acuity tier.
 - i. New providers, provider acquisitions, mergers and change in ownership. Any change in provider enrollment status including, but not limited to, new providers, enrolled providers merging into one or more consolidated provider entities, acquisition or takeover of existing HCBS providers,

or change in the majority ownership of a provider on or after December 1, 2017, shall require the new provider entity to use the tiered rate fee schedule in accordance with paragraph 79.1(1)“c.”

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 9966B**, IAB 2/8/12, effective 1/19/12; **ARC 0028C**, IAB 3/7/12, effective 4/11/12; **ARC 0029C**, IAB 3/7/12, effective 4/11/12; **ARC 9959B** nullified (See nullification note at end of chapter); **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0194C**, IAB 7/11/12, effective 7/1/12; **ARC 0196C**, IAB 7/11/12, effective 7/1/12; **ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0358C**, IAB 10/3/12, effective 11/7/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0355C**, IAB 10/3/12, effective 12/1/12; **ARC 0354C**, IAB 10/3/12, effective 12/1/12; **ARC 0360C**, IAB 10/3/12, effective 12/1/12; **ARC 0485C**, IAB 12/12/12, effective 2/1/13; **ARC 0545C**, IAB 1/9/13, effective 3/1/13; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0581C**, IAB 2/6/13, effective 4/1/13; **ARC 0585C**, IAB 2/6/13, effective 1/9/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0708C**, IAB 5/1/13, effective 7/1/13; **ARC 0710C**, IAB 5/1/13, effective 7/1/13; **ARC 0713C**, IAB 5/1/13, effective 7/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 0823C**, IAB 7/10/13, effective 9/1/13; **ARC 0838C**, IAB 7/24/13, effective 7/1/13; **ARC 0840C**, IAB 7/24/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 0848C**, IAB 7/24/13, effective 7/1/13; **ARC 0864C**, IAB 7/24/13, effective 7/1/13; **ARC 0994C**, IAB 9/4/13, effective 11/1/13; **ARC 1051C**, IAB 10/2/13, effective 11/6/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1057C**, IAB 10/2/13, effective 11/6/13; **ARC 1058C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1150C**, IAB 10/30/13, effective 1/1/14; **ARC 1152C**, IAB 10/30/13, effective 1/1/14; **ARC 1154C**, IAB 10/30/13, effective 1/1/14; **ARC 1481C**, IAB 6/11/14, effective 8/1/14; **ARC 1519C**, IAB 7/9/14, effective 7/1/14; **ARC 1521C**, IAB 7/9/14, effective 7/1/14; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 1608C**, IAB 9/3/14, effective 10/8/14; **ARC 1609C**, IAB 9/3/14, effective 10/8/14; **ARC 1699C**, IAB 10/29/14, effective 1/1/15; **ARC 1697C**, IAB 10/29/14, effective 1/1/15; **ARC 1977C**, IAB 4/29/15, effective 7/1/15; **ARC 2026C**, IAB 6/10/15, effective 8/1/15; **ARC 2075C**, IAB 8/5/15, effective 7/15/15; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2167C**, IAB 9/30/15, effective 11/4/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2341C**, IAB 1/6/16, effective 2/10/16; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2846C**, IAB 12/7/16, effective 11/15/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2930C**, IAB 2/1/17, effective 4/1/17; **ARC 2932C**, IAB 2/1/17, effective 3/8/17; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3158C**, IAB 7/5/17, effective 7/1/17; **ARC 3161C**, IAB 7/5/17, effective 7/1/17; **ARC 3162C**, IAB 7/5/17, effective 7/1/17; **ARC 3160C**, IAB 7/5/17, effective 7/1/17; **ARC 3159C**, IAB 7/5/17, effective 7/1/17; **ARC 3294C**, IAB 8/30/17, effective 10/4/17; **ARC 3295C**, IAB 8/30/17, effective 10/4/17; **ARC 3296C**, IAB 8/30/17, effective 10/4/17; **ARC 3292C**, IAB 8/30/17, effective 10/4/17; **ARC 3293C**, IAB 8/30/17, effective 10/4/17; **ARC 3481C**, IAB 12/6/17, effective 12/1/17; **ARC 3494C**, IAB 12/6/17, effective 1/10/18; **ARC 3551C**, IAB 1/3/18, effective 2/7/18; **ARC 3716C**, IAB 3/28/18, effective 5/2/18; **ARC 3790C**, IAB 5/9/18, effective 6/13/18; **ARC 4067C**, IAB 10/10/18, effective 11/14/18; **ARC 4065C**, IAB 10/10/18, effective 12/1/18; **ARC 4066C**, IAB 10/10/18, effective 12/1/18; **ARC 4068C**, IAB 10/10/18, effective 12/1/18; **ARC 4430C**, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; **ARC 4899C**, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; **ARC 4974C**, IAB 3/11/20, effective 4/15/20; **ARC 5175C**, IAB 9/9/20, effective 6/1/21; **ARC 5305C**, IAB 12/2/20, effective 2/1/21]

441—79.2(249A) Sanctions.

79.2(1) Definitions.

“*Affiliates*” means persons having an overt or covert relationship such that any one of them directly or indirectly controls or influences or has the power to control or influence another.

“*Iowa Medicaid enterprise*” means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services for the benefit of Medicaid members.

“*Person*” means any individual human being or any company, firm, association, corporation, institution, or other legal entity. “*Person*” includes but is not limited to a provider and any affiliate of a provider.

“*Probation*” means a specified period of conditional participation in the medical assistance program.

“*Provider*” means an individual human being, firm, corporation, association, institution, or other legal entity, which is providing or has been approved to provide medical assistance to a member pursuant to the state medical assistance program.

“*Suspension from participation*” means an exclusion from participation for a specified period of time.

“*Suspension of payments*” means the temporary cessation of payments due a person until the resolution of a matter in dispute between a person and the department.

“Termination from participation” means a permanent exclusion from participation in the medical assistance program.

“Withholding of payments” means a reduction or adjustment of the amounts paid to a person on pending and subsequently submitted bills for purposes of offsetting payments made to, received by, or in the possession of a person.

79.2(2) Grounds for sanctions. The department may impose sanctions against any person when appropriate. Appropriate grounds for the department to impose sanctions include, but are not limited to, the following:

a. Presenting or causing to be presented for payment any false, intentionally misleading, or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of obtaining greater compensation than that to which the person is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements.

d. Upon lawful demand, failing to disclose or make available to the department, the department’s authorized agent, any law enforcement or peace officer, any agent of the department of inspections and appeals’ Medicaid fraud control unit, any agent of the auditor of state, the Iowa department of justice, any false claims investigator as defined under Iowa Code chapter 685, or any other duly authorized federal or state agent or agency records of services provided to medical assistance members or records of payments made for those services.

e. Failing to provide or maintain quality services, or a requisite assurance of a framework of quality services to medical assistance recipients within accepted medical community standards as adjudged by professional peers if applicable. For purposes of this subrule, “quality services” means services provided in accordance with the applicable rules and regulations governing the services.

f. Engaging in a course of conduct or performing an act which is in violation of any federal, state, or local statute, rule, regulation, or ordinance, or an applicable contractual provision, that relates to, or arises out of, any publicly or privately funded health care program, including but not limited to any state medical assistance program.

g. Submitting a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or the department’s representative or to any other publicly or privately funded health care program.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing a member to receive services or merchandise not required or requested.

i. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto, or violating any federal or state false claims Act, including but not limited to Iowa Code chapter 685.

j. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information in an application for provider status under the medical assistance program or any quality review or other submission required to maintain good standing in the program.

k. Violating any law, regulation, or code of ethics governing the conduct of an occupation, profession, or other regulated business activity, when the violation relates to, or arises out of, the delivery of services under the state medical assistance program.

l. Breaching any settlement or similar agreement with the department, or failing to abide by the terms of any agreement with any other entity relating to, or arising out of, the state medical assistance program.

m. Failing to meet standards required by state or federal law for participation, including but not limited to licensure.

n. Exclusion from Medicare or any other state or federally funded medical assistance program.

o. Except as authorized by law, charging a person for covered services over and above what the department paid or would pay or soliciting, offering, or receiving a kickback, bribe, or rebate, or accepting or rebating a fee or a charge for medical assistance or patient referral, or a portion thereof. This ground does not include the collection of a copayment or deductible if otherwise allowed by law.

- p.* Failing to correct a deficiency in provider operations after receiving notice of the deficiency from the department or other federal or state agency.
- q.* Formal reprimand or censure by an association of the provider's peers or similar entity related to professional conduct.
- r.* Suspension or termination for cause from participation in another program, including but not limited to workers' compensation or any publicly or privately funded health care program.
- s.* Indictment or other institution of criminal charges for, or plea of guilty or nolo contendere to, or conviction of, any crime punishable by a term of imprisonment greater than one year, any crime of violence, any controlled substance offense, or any crime involving an allegation of dishonesty or negligent practice resulting in death or injury to a provider's patient.
- t.* Violation of a condition of probation, suspension of payments, or other sanction.
- u.* Loss, restriction, or lack of hospital privileges for cause.
- v.* Negligent, reckless, or intentional endangerment of the health, welfare, or safety of a person.
- w.* Billing for services provided by an excluded, nonenrolled, terminated, suspended, or otherwise ineligible provider or person.
- x.* Failing to submit a self-assessment, corrective action plan, or other requirement for continued participation in the medical assistance program, or failing to repay an overpayment of medical assistance funds, in a timely manner, as set forth in a rule or other order.
- y.* Attempting, aiding or abetting, conspiring, or knowingly advising or encouraging another person in the commission of one or more of the grounds specified herein.

79.2(3) Sanctions.

- a.* The department may impose any of the following sanctions on any person:
 - (1) A term of probation for participation in the medical assistance program.
 - (2) Termination from participation in the medical assistance program.
 - (3) Suspension from participation in the medical assistance program.
 - (4) Suspension of payments in whole or in part.
 - (5) Prior authorization of services.
 - (6) Review of claims prior to payment.
- b.* The withholding of a payment or a recoupment of medical assistance funds is not, in itself, a sanction. Overpayments, civil monetary penalties, and interest may also be withheld from payments without imposition of a sanction.
- c.* Mandatory suspensions and terminations.
 - (1) Suspension or termination from participation in the medical assistance program is mandatory when a person is suspended or terminated from participation in the Medicare program, another state's medical assistance program, or by any licensing body. The suspension or termination from participation in the medical assistance program shall be retroactive to the date established by the Centers for Medicare and Medicaid Services or other state or body and, in the case of a suspension, must continue until at least such time as the Medicare or other state's or body's suspension ends.
 - (2) Termination is mandatory upon entry of final judgment, in the Iowa district court or a federal district court of the United States, of liability of the person in a false claims action.
 - (3) Suspension from participation is mandatory whenever a person, or an affiliate of the person, has an outstanding overpayment of medical assistance funds, as defined in Iowa Code chapter 249A.
 - (4) Upon notification from the U.S. Department of Justice, the Iowa department of justice, the department of inspections and appeals, or a similar agency, that a person has failed to respond to a civil investigative demand or other subpoena in a timely manner as set forth in governing law and the demand or other subpoena itself, the department shall immediately suspend the person from participation and suspend all payments to the person. The suspension and payment suspension shall end upon notification that the person has responded to the demand in full.

79.2(4) Imposition and extent of sanction. The department shall consider the totality of the circumstances in determining the sanctions to be imposed. The factors the department may consider include, but are not limited to:

- a.* Seriousness of the offense.

- b. Extent of violations.
- c. History of prior violations.
- d. Prior imposition of sanctions.
- e. Prior provision of provider education (technical assistance).
- f. Provider willingness to obey program rules.
- g. Whether a lesser sanction will be sufficient to remedy the problem.
- h. Actions taken or recommended by peer review groups or licensing boards.

79.2(5) Scope of sanction.

a. Suspension or termination from participation shall preclude the person from submitting claims for payment, whether personally or through claims submitted by any other person or affiliate, for any services or supplies except for those services provided before the suspension or termination.

b. No person may submit claims for payment for any services or supplies provided by a person or affiliate who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

c. When the provisions of this subrule are violated, the department may sanction any person responsible for the violation.

79.2(6) Notice to third parties. When a sanction is imposed, the department may notify third parties of the findings made and the sanction imposed, including but not limited to law enforcement or peace officers and federal or state agencies. The imposition of a sanction is not required before the department may notify third parties of a person's conduct. In accordance with 42 CFR § 1002.212, the department must notify other state agencies, applicable licensing boards, the public, and Medicaid members, as provided in 42 CFR §§ 1001.2005 and 1001.2006, whenever the department initiates an exclusion under 42 CFR § 1002.210.

79.2(7) Notice of violation.

a. Any order of sanction shall be in writing and include the name of the person subject to sanction, identify the ground for the sanction and its effective date, and be sent to the person's last-known address. If the department sanctions a provider, the order of sanction shall also include the national provider identification number of the provider and be sent to the provider's last address on file within the medical assistance program. Proof of mailing to such address shall be conclusive evidence of proper service of the sanction upon the provider.

b. In the case of a currently enrolled provider otherwise in good standing with all program requirements, the provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken. If the provider fails to do so, the sanction shall remain effective pending any subsequent appeal under 441—Chapter 7. If the provider attempts to show cause but the department determines the sanction should remain effective pending any subsequent appeal under 441—Chapter 7, the provider may seek a temporary stay of the department's action from the director or the director's designee by filing an application for stay with the appeals section. The director or the director's designee shall consider the factors listed in Iowa Code section 17A.19(5) "c."

79.2(8) Suspension or withholding of payments. The department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question due to a sanction, incorrect payment, civil monetary penalty, or other adverse action and may also suspend payment or participation pending a final determination. If the department withholds or suspends payments, it shall notify the person in writing within the time frames prescribed by federal law for cases related to a credible allegation of fraud, and within ten days for all other cases.

79.2(9) Civil monetary penalties and interest. Civil monetary penalties and interest assessed in accordance with 2013 Iowa Acts, Senate File 357, section 5 or section 11, are not allowable costs for any aspect of determining payment to a person within the medical assistance program. Under no circumstance shall the department reimburse a person for such civil monetary penalties or interest.

79.2(10) Report and return of identified overpayment.

a. If a person has identified an overpayment, the person must report and return the overpayment in the form and manner set forth in this subrule.

b. A person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of the overpayment.

c. An overpayment required to be reported under 2013 Iowa Acts, Senate File 357, section 3, must be made in writing, addressed to the Program Integrity Unit of the Iowa Medicaid Enterprise, and contain all of the following:

- (1) Person's name.
- (2) Person's tax identification number.
- (3) How the error was discovered.
- (4) The reason for the overpayment.
- (5) Claim number(s), as appropriate.
- (6) Date(s) of service.
- (7) Member identification number(s).
- (8) National provider identification (NPI) number.
- (9) Description of the corrective action plan to ensure the error does not occur again, if applicable.
- (10) Whether the person has a corporate integrity agreement with the Office of the Inspector General (OIG) or is under the OIG Self-Disclosure Protocol or is presently under sanction by the department.
- (11) The time frame and the total amount of refund for the period during which the problem existed that caused the refund.
- (12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.
- (13) A refund in the amount of the overpayment.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—79.3(249A) Maintenance of records by providers of service. A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the department or to its authorized representative timely upon request shall result in claim denial or recoupment.

79.3(1) Financial (fiscal) records.

a. A provider of service shall maintain records as necessary to:

- (1) Support the determination of the provider's reimbursement rate under the medical assistance program; and
- (2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.

b. A financial record does not constitute a medical record.

79.3(2) Medical (clinical) records. A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing.

a. Definition. "Medical record" (also called "clinical record") means a tangible history that provides evidence of:

- (1) The provision of each service and each activity billed to the program; and
- (2) First and last name of the member receiving the service.

b. Purpose. The medical record shall provide evidence that the service provided is:

- (1) Medically necessary;
- (2) Consistent with the diagnosis of the member's condition; and
- (3) Consistent with professionally recognized standards of care.

c. Components.

- (1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the

medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2) "d." The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.

13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided. Service documentation shall include narrative documentation and may also include documentation in checkbox format. The service record shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those non-time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5) "c" or "d," 441—paragraph 77.33(6) "d," 441—paragraph 77.34(5) "d," 441—paragraph 77.37(15) "d," 441—paragraph 77.39(13) "e," 441—paragraph 77.39(14) "d," or 441—paragraph 77.46(5) "i," or 441—subparagraph 78.9(10) "a"(1).
5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
6. Any supplies dispensed as part of the service.
7. The first and last name and professional credentials, if any, of the person providing the service.
8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.
9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

d. Basis for service requirements for specific services. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise program integrity unit requests providers to submit records for review. (See paragraph 79.4(2) "b.")

- (1) Physician (MD and DO) services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
- (2) Pharmacy services:
 1. Prescriptions.
 2. Nursing facility physician order.
 3. Telephone order.
 4. Pharmacy notes.
 5. Prior authorization documentation.
- (3) Dentist services:
 1. Treatment notes.
 2. Anesthesia notes and records.
 3. Prescriptions.
- (4) Podiatrist services:
 1. Service or office notes or narratives.
 2. Certifying physician statement.
 3. Prescription or order form.
- (5) Certified registered nurse anesthetist services:
 1. Service notes or narratives.
 2. Preanesthesia physical examination report.
 3. Operative report.
 4. Anesthesia record.
 5. Prescriptions.
- (6) Other advanced registered nurse practitioner services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Other service documentation as applicable.
- (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.
 3. Other service documentation as applicable.
- (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.
 7. Other service documentation as applicable.
- (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.
 4. Other service documentation as applicable.
- (25) Behavioral health intervention:
1. Order for services.

2. Comprehensive treatment or service plan (initial and subsequent).
 3. Service notes or narratives.
 4. Other service documentation as applicable.
- (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, nurse practitioner, physician assistant, or clinical nurse specialist 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. Notice of decision for service authorization.
 2. Service notes or narratives.
 3. Social history.
 4. Comprehensive service plan.
 5. Reassessment of member needs.
 6. Incident reports in accordance with 441—subrule 24.4(5).
 7. Other service documentation as applicable.
- (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.
8. Other service documentation as applicable.
- (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. Waiver of informed consent.
 3. Prior authorization documentation.
 4. Service or office notes or narratives.
- (39) Behavioral health services:
 1. Assessment.
 2. Individual treatment plan.
 3. Service or office notes or narratives.
 4. Other service documentation as applicable.
- (40) Health home services:
 1. Comprehensive care management plan.
 2. Care coordination and health promotion plan.
 3. Comprehensive transitional care plan, including appropriate follow-up, from inpatient to other settings.
 4. Documentation of member and family support (including authorized representatives).
 5. Documentation of referral to community and social support services, if relevant.
- (41) Services of public health agencies:
 1. Service or office notes or narratives.
 2. Immunization records.
 3. Results of communicable disease testing.
- (42) Community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services:
 1. Department-approved standardized neurobehavioral assessment tool.
 2. Community-based neurobehavioral treatment order.
 3. Treatment plan.
 4. Clinical records documenting diagnosis and treatment history.
 5. Progress or status notes.
 6. Service notes or narratives.
 7. Procedure, laboratory, or test orders and results.
 8. Therapy notes including but not limited to occupational therapy, physical therapy, and speech-language pathology services as applicable.
 9. Medication administration records.
 10. Other service documentation as applicable.
- (43) Child care medical services:
 1. Plan of care.
 2. Certification and recertification.
 3. Service notes or narratives.
 4. Physician orders or medical orders.
 5. Abbreviation list (a copy of the abbreviation list utilized within the member's record).

6. If initials or incomplete signatures are noted within the member's record, a signature log (a typed listing of each provider's name, including initials, professional credentials and title, followed by the individual provider's signature).

(44) Subacute mental health services.

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. Medication administration records (residential services).

(45) Crisis response services, crisis stabilization community-based services and crisis stabilization residential services.

1. Assessment.
2. Individual stabilization plan.
3. Service notes or narratives (history and physical, therapy records, discharge summary).
4. Medication administration records (residential services).

e. Corrections. A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

(2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

79.3(3) Maintenance requirement. The provider shall maintain records as required by this rule:

- a.* During the time the member is receiving services from the provider.
- b.* For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.
- c.* As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

79.3(4) Availability. Rescinded IAB 1/30/08, effective 4/1/08.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 8262B, IAB 11/4/09, effective 12/9/09; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0358C, IAB 10/3/12, effective 11/7/12; ARC 0711C, IAB 5/1/13, effective 7/1/13; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 3358C, IAB 10/11/17, effective 10/1/17; ARC 3551C, IAB 1/3/18, effective 2/7/18; ARC 3554C, IAB 1/3/18, effective 2/7/18; ARC 3716C, IAB 3/28/18, effective 5/2/18; ARC 4751C, IAB 11/6/19, effective 12/11/19; ARC 5487C, IAB 3/10/21, effective 4/14/21]

441—79.4(249A) Reviews and audits.

79.4(1) Definitions.

“*Authorized representative,*” within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

“*Claim*” means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

“*Clinical record*” means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

“*Confidence level*” means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

“*Customary and prevailing fee*” means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

“*Extrapolation*” means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

“*Fiscal record*” means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

“*Overpayment*” means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

“*Procedure code*” means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

“*Random sample*” means a statistically valid random sample for which the probability of selection for every item in the universe is known.

“*Underpayment*” means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

“*Universe*” means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) *Audit or review of clinical and fiscal records by the department.* Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records to determine whether:

- (1) The department has correctly paid claims for goods or services.
- (2) The provider has furnished the services to Medicaid members.
- (3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.
- (4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise program integrity unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)“d” to document the basis for services or activities provided.

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph “b.”

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider’s designee. The request must:

1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.

(2) For purposes of these rules, “good cause” has the same meaning as in Iowa Rule of Civil Procedure 1.977.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

f. Self-audit. The department may require a provider to conduct a self-audit and report the results of the self-audit to the department.

79.4(4) Preliminary report of audit or review findings. If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) Disagreement with audit or review findings. If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. *Reevaluation request.* A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. *Additional information.* A provider that has made a reevaluation request pursuant to paragraph "a" of this subrule may submit clarifying information or supplemental documentation that was not

previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph “c” of this subrule.

c. Disagreement with sampling results. When the department’s audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department’s sample. Any such audit or review must:

- (1) Be arranged and paid for by the provider.
- (2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.
- (3) Be conducted by a certified public accountant if the issues relate to fiscal records.
- (4) Demonstrate that bills and records that were not audited or reviewed in the department’s sample are in compliance with program regulations.
- (5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) Finding and order for repayment. Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) Appeal by provider of care. A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment. Records not provided to the department during the review process set forth in subrule 79.4(3) or 79.4(5) shall not be admissible in any subsequent contested case proceeding arising out of a finding and order for repayment of any overpayment identified under subrule 79.4(6). This provision does not preclude providers that have provided records to the department during the review process set forth in subrule 79.4(3) or 79.4(5) from presenting clarifying information or supplemental documentation in the appeals process in order to defend against any overpayment identified under subrule 79.4(6). This provision is intended to minimize potential duplication of effort and delay in the audit or review process, minimize unnecessary appeals, and otherwise forestall fraud, waste, and abuse in the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0712C, IAB 5/1/13, effective 7/1/13; ARC 1155C, IAB 10/30/13, effective 1/1/14]

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department’s policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

This rule is intended to implement Iowa Code section 249A.4.

441—79.7(249A) Medical assistance advisory council.

79.7(1) Officers.

a. The public co-chairperson's term of office shall be two years. A public co-chairperson shall serve no more than two consecutive terms.

b. The public co-chairperson shall have the right to vote on any issue before the council. The public health director co-chairperson serves as a nonvoting member of the council.

c. The position of public co-chairperson shall be held by one of the five public council members. Ballots will be distributed to the public council members at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by department of human services staff. The initial ballot following July 1, 2019, will be distributed by email prior to the first meeting in that fiscal year in order to identify the public co-chairperson prior to the council's first meeting.

d. The co-chairpersons shall appoint members to other committees approved by the council.

e. Responsibilities.

(1) The co-chairpersons shall be responsible for development of the agendas for meetings of the council. Agendas will be developed and distributed in compliance with the advance notice requirements of Iowa Code section 21.4. Agendas will be developed in consultation with the staff and director of human services, taking into consideration the following:

1. Workplans. Items will be added to the council's agenda as various tasks for the council are due to be discussed based on calendar requirements. Council deliberations are to be conducted within a time frame to allow the council to receive and make recommendations to the director and for the director to consider those recommendations as budgets and policy for the medical assistance program are developed for the review of the council on human services and the governor, as well as for the upcoming legislative session.

2. Requests from the director of human services.

3. Discussion and action items from council members. The co-chairpersons will review any additional suggestions from council members at any time, including after the draft agenda has been distributed. The agenda will be distributed in draft form five business days prior to the council meeting, and the final agenda will be distributed no later than 24 hours prior to the council meeting.

(2) The co-chairpersons shall preside over all council meetings, calling roll, determining a quorum, counting votes, and following the agenda for the meeting.

(3) The co-chairpersons shall consult with the department of human services on other administrative tasks to oversee the council and shall participate in workgroups and subcommittees as appropriate.

79.7(2) Membership. The membership of the council shall be as prescribed in Iowa Code section 249A.4B.

a. Council membership of professional and business entities shall number five and be identified from a vote among those entities outlined in Iowa Code section 249A.4B(3). Professional and business entities shall vote every year to identify the entities and their subsequent representatives that will represent the body of professional and business stakeholders on the council. Professional and business entities will also report their contact information to the department of human services.

(1) An initial election in SFY 2020 of five professional and business members shall be held. From this initial election of five members, three members with the most votes shall serve a three-year term and the other two members shall serve a two-year term. Once these members have served their initial term, the length of term for all following elected members shall be two years.

(2) Elections shall be organized along the following guidelines.

1. Ballots will be distributed at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and counted by department of human services staff.

2. The entities that receive the most votes shall serve on the council.

(3) Should any vacancy occur on the council, the entity that received the next highest number of votes in the most recent election shall serve on the council.

(4) If a voting entity's representative does not attend more than three consecutive meetings, the department of human services will notify the entity and representative and verify whether an alternative contact is needed. If a fourth consecutive meeting is missed after the notification, the voting entity's seat will be considered vacant and will be filled as outlined in subparagraph 79.7(2) "a"(3).

b. Council membership of public representatives shall consist of five representatives, of which one must be a recipient of medical assistance. All five public representatives will be appointed by the governor for staggered terms of two years each. All five public representatives will be voting members of the council.

c. A member of the hawki board, created in Iowa Code section 514I.5, selected by the members of the hawki board, shall be a member of the council. The hawki board member representative will be a nonvoting member of the council.

d. Council membership shall also consist of state agency and medical school partners, including representatives from the department of public health, the department on aging, the office of the long-term care ombudsman, Des Moines University and the University of Iowa College of Medicine.

(1) Partner agency and medical school representatives will be nonvoting members of the council.

(2) If an agency's or school's representative does not attend more than three consecutive meetings, the department of human services will notify the agency or school.

(3) Partner agencies and medical schools shall determine the length of appointment of their representatives. The department of human services will confirm each representative's participation every two years.

e. The following members of the general assembly shall be members of the council, each for a term of two years as provided in Iowa Code section 69.16B. Members appointed from the general assembly will serve as nonvoting members of the council.

(1) Two members of the house of representatives, one appointed by the speaker of the house of representatives and one appointed by the minority leader of the house of representatives from their respective parties.

(2) Two members of the senate, one appointed by the president of the senate after consultation with the majority leader of the senate and one appointed by the minority leader of the senate from their respective parties.

79.7(3) Responsibilities, duties and meetings. The responsibility of the medical assistance advisory council is to provide recommendations on the medical assistance program to the department of human services .

a. *Recommendations.* Recommendations made by the council shall be advisory and not binding upon the department of human services or the professional and business entities represented. The director of the department of human services shall consider the recommendations in the director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3 and implementation of medical assistance program policies.

b. *Council.* The council shall be provided with information to deliberate and provide input on the medical assistance program. The council will use that input in making final recommendations to the department of human services.

(1) Council meetings.

1. The council will meet no more than quarterly.

2. Meetings may be called by the co-chairpersons; upon written request of at least 50 percent of members; or by the director of the department of human services.

3. Meetings shall be held in the Des Moines, Iowa, area unless other notification is given. Meetings will also be made available via teleconference, when available.

4. Written notice of council meetings shall be electronically mailed at least five business days in advance of the meeting. Each notice shall include an agenda for the meeting. The final agenda will be distributed no later than 24 hours prior to the meeting.

(2) The council shall advise the professional and business entities represented and act as liaison between them and the department.

(3) The council shall perform other functions as may be provided by state or federal law or regulation.

(4) Pursuant to 2016 Iowa Acts, chapter 1139, section 93, the council shall regularly review Medicaid managed care. The council shall submit an executive summary of pertinent information regarding deliberations during the prior year relating to Medicaid managed care to the department of human services no later than November 15 annually.

(5) Pursuant to 2016 Iowa Acts, chapter 1139, section 94, the council shall submit to the chairpersons and ranking members of the human resources committees of the senate and house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, on a quarterly basis, minutes of the council meetings during which the council addressed Medicaid managed care.

79.7(4) Procedures.

a. A quorum shall consist of 50 percent (five persons) of the current voting members.

b. Where a quorum is present, a position is carried by two-thirds of the present council members .

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member of the council.

d. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(5) Expenses, staff support, and technical assistance. Expenses of the council, 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 .

a. The department shall provide reports, data, and proposed and final amendments to rules, laws, and guidelines to the council for its information, review, and comment.

b. The department shall present the annual budget for the medical assistance program for review and comment.

c. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

d. The department shall maintain a current list of members on the council .

e. The department shall be responsible for the organization of all council meetings and notice of meetings.

f. As required in Iowa Code section 21.3, minutes of the meetings of the council will be kept by the department. The council will review minutes before distribution to the public.

[ARC 8263B, IAB 11/4/09, effective 12/9/09; ARC 3006C, IAB 3/29/17, effective 6/1/17; ARC 4975C, IAB 3/11/20, effective 4/15/20]

441—79.8(249A) Requests for prior authorization. This rule governs requests for prior authorization for services not provided through a managed care organization. For services provided through a managed care organization, the prior authorization request is submitted, reviewed, and authorized by the managed care organization.

79.8(1) Making the request.

a. Providers may submit requests for prior authorization for any items or procedures, other than prescription drugs, by mail or by facsimile transmission (fax) using Form 470-5595, Outpatient Prior Authorization Request, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs must be submitted on any Request for Prior Authorization form designated for the drug being requested in the preferred drug list published pursuant to Iowa Code chapter 249A.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-0829, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-0829 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 of prescription drugs 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.

c. Decisions regarding approval or denial for items or procedures other than prescription drugs will be made according to the time frames set forth in 42 CFR 438.210(d).

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78.

a. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

(1) The conditions for payment outlined in the provider manual with reference to coverage and duration.

(2) The determination made by the Medicare program unless specifically stated differently in state law or rule.

(3) The recommendation to the department from the appropriate advisory committee.

(4) Whether there are other less expensive procedures which are covered and which would be as effective.

(5) The advice of an appropriate professional consultant.

b. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 16. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4751C, IAB 11/6/19, effective 12/11/19; ARC 4973C, IAB 3/11/20, effective 4/15/20; ARC 5362C, IAB 12/30/20, effective 3/1/21]

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

- a. Be consistent with the diagnosis and treatment of the patient's condition.
- b. Be in accordance with standards of good medical practice.
- c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.
- d. Be the least costly type of service which would reasonably meet the medical need of the patient.
- e. Be eligible for federal financial participation unless specifically covered by state law or rule.
- f. Be within the scope of the licensure of the provider.
- g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.
- h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

79.9(6) The acceptance of Medicaid funds by means of a prospective or interim rate creates an express trust. The Medicaid funds received constitute the trust res. The trust terminates when the rate is retrospectively adjusted or otherwise finalized and, if applicable, any Medicaid funds determined to be owed are repaid in full to the department.

79.9(7) Incorrect payment.

a. Except as provided in paragraph 79.9(7)“b,” medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.9(7)“a,” medical assistance funds are not incorrectly paid when an individual who serves as a member's legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013. For purposes of this paragraph, “legal representative” means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger.

79.9(8) The rules of the medical assistance program shall not be construed to require payment of medical assistance funds, in whole or in part, directly or indirectly, overtly or covertly, for the provision of non-Medicaid services. The rules of the medical assistance program shall be interpreted in such a manner to minimize any risk that medical assistance funds might be used to subsidize services to persons other than members of the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2014 Iowa Acts, Senate File 2320.
 [ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1610C, IAB 9/3/14, effective 8/13/14]

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 73.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 73.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—79.12(249A) Advance directives. "Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving

medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person's admission as an inpatient, a home health care provider in advance of a person's coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider's policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

This rule is intended to implement Iowa Code section 249A.4.

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

This rule is intended to implement Iowa Code section 249A.4.

441—79.14(249A) Provider enrollment.

79.14(1) Application request. Iowa Medicaid providers, including those enrolled with a managed care organization, shall begin the enrollment process by completing the appropriate application on the Iowa Medicaid enterprise website. Managed care organizations and fiscal agents are exempt from completing an application.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. Providers enrolling as ordering or referring providers shall submit Form 470-5111, Iowa Medicaid Ordering/Referring Provider Enrollment Application.

c. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

d. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

e. An intermediate care facility for persons with an intellectual disability shall also complete the process set forth in 441—subrule 82.3(1).

f. Qualified Medicare beneficiary (QMB) providers shall enroll using Form 470-5262, Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application.

g. Health insurance premium payment (HIPP) providers shall enroll using Form 470-5262, Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application.

79.14(2) Submittal of application. The provider shall submit the appropriate application forms, including the application fee, if required, to the Iowa Medicaid enterprise provider services unit by personal delivery, by email, via online enrollment systems, or by mail to P.O. Box 36450, Des Moines, Iowa 50315.

a. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

b. With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

c. With the application form, or as a supplement to a previously submitted application, providers of health home services shall submit Form 470-5100, Health Home Provider Agreement.

d. Application fees.

(1) Providers who are enrolling or reenrolling in the Iowa Medicaid program shall submit an application fee with their application unless they are exempt as set forth in this paragraph.

(2) Fee amount. The application fee shall be in the amount prescribed by the Secretary of the U.S. Department of Health and Human Services (the Secretary) for the calendar year in which the application is submitted and in accordance with 42 U.S.C. 1395cc(j)(2)(C).

(3) Nonrefundable. The application fee is nonrefundable, except if submitted with one of the following:

1. A hardship exception request that is subsequently approved by the Secretary.

2. An application that is subsequently denied as a result of a temporary moratorium under 2013 Iowa Acts, Senate File 357, section 12.

3. An application or other transaction in which the application fee is not required.

(4) The process for enrolling or reenrolling a provider will not begin until the application fee has been received by the department or a hardship exception request has been approved by the Secretary.

(5) Exempt providers. The following providers shall not be required to submit an application fee:

1. Individual physicians or nonphysician practitioners.

2. Providers that are enrolled in Medicare, another state's Medicaid program or another state's children's health insurance program.

3. Providers that have paid the applicable application fee within 12 months of the date of application submission to a Medicare contractor or another state.

(6) All application fees collected shall be used for the costs associated with the screening procedures as described in subrule 79.14(4). Any unused portion of the application fees collected shall be returned to the federal government in accordance with 42 CFR § 455.460.

79.14(3) Program integrity information requirements.

a. All providers, including but not limited to managed care organizations and Medicaid fiscal agents, applying for participation in the Iowa Medicaid program must disclose all information required to be submitted pursuant to 42 CFR Part 455. In addition, all providers shall disclose any current, or previous, direct or indirect affiliation with a present or former Iowa Medicaid provider that:

(1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;

(2) Has been or is subject to a payment suspension under a federally funded health care program;

(3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;

(4) Has had its billing privileges denied or revoked;

(5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or

(6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.14(3) “a”(1), (2), (3), (4), or (5).

b. The Iowa Medicaid enterprise may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 7 but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse. The Iowa Medicaid enterprise shall deny enrollment to or shall immediately disenroll any person that the Iowa Medicaid enterprise, Medicare, or any other state Medicaid program has ever terminated under rule 441—79.2(249A) or a similar provision and shall deny enrollment to any person presently suspended from participation, or who would be subject to a suspension, under paragraph 79.2(3) “c.” Further, a person sanctioned under rule 441—79.2(249A) or a similar provision may not manage consumer choices option (CCO) funds for a member.

c. For purposes of this rule, the term “direct or indirect affiliation” includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:

- (1) A compensation arrangement;
- (2) An ownership arrangement;
- (3) Managerial authority over any member of the affiliation;
- (4) The ability of one member of the affiliation to control or influence any other; or
- (5) The ability of a third party to control or influence any member of the affiliation.

d. Notwithstanding any previous successful enrollment in the medical assistance program, the passing of any background check by the department or any other entity, or similar prior approval for participation as a provider in the medical assistance program, in whole or in part, disenrollment from the medical assistance program is mandatory when, in the case of a corporation or similar entity, 5 percent or more of the corporation or similar entity is owned, controlled, or directed by a person who (1) has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry; (2) has pled guilty or nolo contendere to, or was convicted of, any crime punishable by a term of imprisonment greater than five years; (3) has, within the last five years, pled guilty or nolo contendere to, or was convicted of, any controlled substance offense; (4) has, within the last ten years, pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty punishable by a term of imprisonment greater than one year but not more than five years; or (5) within the last ten years, has on more than one occasion pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty.

79.14(4) Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the “limited,” “moderate,” or “high” categorical risk screening procedures and requirements in accordance with 42 CFR §455.450.

a. For the types of providers that are recognized as a provider under the Medicare program, the Iowa Medicaid enterprise shall use the same categorical risk screening procedures and requirements assigned to that provider type by Medicare pursuant to 42 CFR §424.518.

b. Provider types not assigned a screening level by the Medicare program shall be subject to the procedures of the “limited” risk screening level pursuant to 42 CFR §455.450.

c. Adjustment of risk level. The Iowa Medicaid enterprise shall adjust the categorical risk screening procedures and requirements from “limited” or “moderate” to “high” when any of the following occurs:

(1) The Iowa Medicaid enterprise imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse; the provider has an existing Medicaid overpayment; or within the previous ten years, the provider has been excluded by the Office of the Inspector General or another state’s Medicaid program; or

(2) The Iowa Medicaid enterprise or the Centers for Medicare and Medicaid Services in the previous six months lifted a temporary moratorium for the particular provider type, and a provider that

was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

79.14(5) Notification. A provider shall be notified of the decision on the provider's application within 30 calendar days of receipt by the Iowa Medicaid enterprise provider services unit of a complete and correct application with all required documents, including, but not limited to, if applicable, any application fees or screening results.

79.14(6) A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 7.

79.14(7) Effective date of approval. An application shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application with all required documents by the Iowa Medicaid enterprise provider services unit.

79.14(8) A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(9) No payment shall be made to a provider for care or services provided prior to the effective date of the Iowa Medicaid enterprise's approval of an application.

79.14(10) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(11) An amendment to an application shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(12) A provider that has not submitted a claim in the last 24 months will be sent a notice asking if the provider wishes to continue participation. A provider that fails to reply to the notice within 30 calendar days of the date on the notice will be terminated as a provider. Providers that do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(13) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 35 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, telephone number, or any information required to be disclosed by subrule 79.14(3).

a. When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, the Iowa Medicaid enterprise may immediately terminate the provider's Medicaid enrollment. The termination may be appealed under 441—Chapter 7. Such termination remains in effect notwithstanding any pending appeal.

b. When the department incurs an informational tax-reporting fine or is required to repay the federal share of medical assistance paid to the provider because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine or repayment shall be the responsibility of the individual provider to the extent that the fine or repayment relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine or repayment to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine or repayment may be appealed under 441—Chapter 7.

79.14(14) Provider termination or denial of enrollment. The Iowa Medicaid enterprise must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416.

79.14(15) Temporary moratoria. The Iowa Medicaid enterprise must impose any temporary moratorium pursuant to 2013 Iowa Acts, Senate File 357, section 12.

79.14(16) Provider revalidation. Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

79.14(17) Recoupment. A provider is strictly liable for any failure to disclose the information required by subrule 79.14(3) or any failure to report a change required by subrule 79.14(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed the Iowa Medicaid enterprise while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13; ARC 1153C, IAB 10/30/13, effective 1/1/14; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least \$5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) Policy requirements. Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

- (1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;
- (2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;
- (3) Any state laws pertaining to civil or criminal penalties for false claims and statements;
- (4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and
- (5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

- (1) The laws described in paragraph 79.15(1)“a”;
- (2) The rights of employees to be protected as whistle blowers; and
- (3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) Reporting requirements.

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

- (1) The name, address, and national provider identification numbers under which the entity receives payment;
- (2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and
- (3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

- (1) Mailing the information to the IME Program Integrity Unit, P.O. Box 36390, Des Moines, Iowa 50315; or

(2) Faxing the information to (515)725-1354.

79.15(3) Enforcement. Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

441—79.16(249A) Electronic health record incentive program. The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

79.16(1) State elections. In addition to the statutory provisions in ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as amended to September 4, 2012. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

a. For purposes of the term “hospital-based eligible professional (EP)” as set forth in 42 CFR Section 495.4 as amended to September 4, 2012, the department elects the calendar year preceding the payment year as the period used to gather data to determine whether or not an eligible professional is “hospital-based” for purposes of the regulation.

b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to September 4, 2012, the department has elected that eligible providers may use either:

(1) The patient encounter methodology found in 42 CFR Section 495.306(c) as amended to September 4, 2012, or

(2) The patient panel methodology found in 42 CFR Section 495.306(d) as amended to September 4, 2012.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to September 4, 2012, the “12-month period selected by the state” shall mean the hospital fiscal year.

d. For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to September 4, 2012, the “12-month period selected by the state” shall mean the hospital fiscal year.

79.16(2) Eligible providers. To be deemed an “eligible provider” for the electronic health record incentive program, a provider must satisfy the applicable criterion in each paragraph of this subrule:

a. The provider must be currently enrolled as an Iowa Medicaid provider.

b. The provider must be one of the following:

(1) An eligible professional, listed as:

1. A physician,
2. A dentist,
3. A certified nurse midwife,
4. A nurse practitioner, or
5. A physician assistant practicing in a federally qualified health center or a rural health clinic

when the physician assistant is the primary provider, clinical or medical director, or owner of the site.

(2) An acute care hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

(3) A children’s hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

c. For the year for which the provider is applying for an incentive payment:

(1) An acute care hospital must have 10 percent Medicaid patient volume.

(2) An eligible professional must have at least 30 percent of the professional’s patient volume enrolled in Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this subrule, a “pediatrician” is a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.

2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the hawki program, and Medicaid members may be counted to meet the 30 percent threshold.

79.16(3) Application and agreement. Any eligible provider that intends to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the CMS Registration and Attestation website, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider's application for the incentive payment.

a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the Iowa EHR Medicaid incentive payment administration website at www.imeincentives.com. The applicant shall use the website to:

- (1) Attest to the applicant's qualifications to receive the incentive payment, and
- (2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.

b. For the second year of participation, eligible providers must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.

c. The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

79.16(4) Payment. The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the CMS Registration and Attestation website.

a. The primary communication channel from the department to the provider will be the Iowa EHR Medicaid incentive payment administration website. 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 website. Providers shall access the website to determine the status of their payment, including whether the department denied payment and the reason for the denial.

b. Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:

- (1) Eligibility,
- (2) Purchase of certified electronic health record technology, and
- (3) Meaningful use of electronic health record technology.

79.16(5) Administrative appeal. Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:

- a. Provider eligibility determination.
- b. Incentive payments.
- c. Demonstration of adopting, implementing, upgrading and meaningful use of technology.

This rule is intended to implement Iowa Code section 249A.4 and Public Law No. 111-5.

[ARC 9254B, IAB 12/1/10, effective 1/1/11; ARC 9531B, IAB 6/1/11, effective 5/12/11; ARC 0824C, IAB 7/10/13, effective 9/1/13]

441—79.17(249A) 2013 reimbursement rate increases. Rescinded ARC 1056C, IAB 10/2/13, effective 11/6/13.

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- [Filed Emergency ARC 0864C, IAB 7/24/13, effective 7/1/13]
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- [Filed Emergency ARC 2075C, IAB 8/5/15, effective 7/15/15]
- [Filed Emergency After Notice ARC 2164C (Notice ARC 2062C, IAB 7/22/15), IAB 9/30/15, effective 10/1/15]
- [Filed ARC 2167C (Notice ARC 2076C, IAB 8/5/15), IAB 9/30/15, effective 11/4/15]
- [Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]
- [Filed ARC 2341C (Notice ARC 2113C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]
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- [Filed ARC 2930C (Notice ARC 2824C, IAB 11/23/16), IAB 2/1/17, effective 4/1/17]
- [Filed ARC 2932C (Notice ARC 2847C, IAB 12/7/16), IAB 2/1/17, effective 3/8/17]
- [Filed ARC 2936C (Notice ARC 2849C, IAB 12/7/16), IAB 2/1/17, effective 3/8/17]
- [Filed ARC 3006C (Notice ARC 2899C, IAB 1/18/17), IAB 3/29/17, effective 6/1/17]
- [Filed Emergency ARC 3158C, IAB 7/5/17, effective 7/1/17]
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- [Filed ARC 3294C (Notice ARC 3165C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]
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- 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 Two ARCs
- ³ 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.
- ⁴ Two or more ARCs
- ⁵ 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.
- ⁶ 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.
- ⁷ 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**.
- ⁸ 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.
- ⁹ Two ARCs
- ¹⁰ 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.
- ¹¹ See HJR 2008 of 2012 Session of the Eighty-fourth General Assembly regarding nullification of amendment to 79.1(7) “b” (ARC 9959B, IAB 1/11/12).
- ¹² July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.
- ¹³ March 18, 2020, effective date of **ARC 4899C** [amendments to chs 78, 79] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held March 6, 2020; delay lifted at the meeting held August 11, 2020.

CHAPTER 83
MEDICAID WAIVER SERVICES

PREAMBLE

Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in a medical institution, including support for persons to seek and maintain employment in the community. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients as the services are beyond the scope of the Medicaid state plan.

[ARC 2471C, IAB 3/30/16, effective 5/4/16]

DIVISION I—HCBS HEALTH AND DISABILITY WAIVER SERVICES

441—83.1(249A) Definitions.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Basic individual respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“Blind individual” means an individual who has a central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

“Client participation” means the amount of the recipient income that the person must contribute to the cost of health and disability waiver services exclusive of medical vendor payments before Medicaid will participate.

“Deeming” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“Disabled person” means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

“Financial participation” means client participation and medical payments from a third party including veterans’ aid and attendance.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Intermittent homemaker service” means homemaker service provided from one to three hours a day for not more than four days per week.

“Intermittent respite service” means respite service provided from one to three times a week.

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

“Medical assessment” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“Medical institution” means a nursing facility or an intermediate care facility for persons with an intellectual disability which has been approved as a Medicaid vendor.

“Medical intervention” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Service plan” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- a. A physician order for all skilled services.

- b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

- c. An individualized care plan that identifies support needs.

- d. Confirmation that skilled services are provided to the member.

- e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

- f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“Specialized respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“Substantial gainful activity” means productive activities which add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

“Third-party payments” means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“Usual caregiver” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—83.2(249A) Eligibility. To be eligible for health and disability waiver services, a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.2(1) Eligibility criteria.

a. The person must be under the age of 65 and blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act.

b. Rescinded IAB 1/2/19, effective 2/6/19.

c. Persons shall meet the eligibility requirements of the supplemental security income program except for the following:

(1) The person is under 18 years of age, unmarried and not the head of a household and is ineligible for supplemental security income because of the deeming of the parent's(s') income.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse's income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person's income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

(4) The person is under 18 years of age and is ineligible for supplemental security income because of excess resources.

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on a completed information submission tool Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 to 64 and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC) and the interRAI - Home Care (HC) are available upon request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

(1) The member's designated case manager shall use the completed assessment to develop the comprehensive service plan as specified in 441—paragraph 90.4(1) "b."

(2) The IME medical services unit shall be responsible for the initial determination of the member's level of care certification. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

(3) Health and disability waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

e. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.

f. The person must meet income and resource guidelines for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2) "b" and 75.5(4) "c" shall be applied.

g. The person must have service needs that can be met by this waiver program. At a minimum a person must receive one billable unit of service under the waiver per calendar quarter.

h. To be eligible for the consumer choices option as set forth in 441—subrule 78.34(13), a person cannot be living in a residential care facility.

83.2(2) Need for services.

a. The member shall have a service plan approved by the department which is developed by the designated case manager. This service plan must be completed prior to services provision and annually thereafter.

The designated case manager shall establish the interdisciplinary team for the member and, with the team, identify the member's need for service based on the member's needs and desires as well as the availability and appropriateness of services, using the following criteria:

(1) This service plan shall be based, in part, on information in the completed information submission tool listed in paragraph 83.2(1)“d” and other supporting documentation as relevant. The designated case manager shall have a face-to-face visit with the member at least quarterly.

(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The designated case manager shall list all nonwaiver Medicaid services in the service plan.

(3) Service plans for persons aged 20 or under that include home health or nursing services shall not be approved until a home health agency has made a request to cover the member's service needs through nonwaiver Medicaid services.

b. Except as provided below, the total monthly cost of the health and disability waiver services, excluding the cost of home and vehicle modification services, shall not exceed the established aggregate monthly cost for level of care as follows:

<u>Skilled level of care</u>	<u>Nursing level of care</u>	<u>ICF/ID</u>
\$2,792.65	\$959.50	\$3,742.93

For members enrolled in the health and disability waiver in accordance with subrule 83.2(1), when a member turns 21 years of age, the average monthly cost of services received through 441—subrule 78.9(10) (state plan private duty nursing or personal care services for persons aged 20 and under) shall be used to increase the monthly waiver budget in accordance with the following:

(1) The member must request the revised waiver budget through the member's case manager no earlier than two months before, and no later than six months after, the member's twenty-first birthday. A renewal request must be received annually no earlier than two months before, and no later than six months after, each subsequent birthday.

(2) The member's waiver budget shall be increased by the average monthly cost of state plan private duty nursing or personal care services for the member that was billed to and paid by Iowa Medicaid or an Iowa Medicaid-contracted managed care organization during the year in which the member is 20 years of age.

(3) Once the request is received by the department, the department shall determine the average monthly cost pursuant to the claims data available at the time of the request. No subsequent claims data shall be considered.

(4) The revised waiver budget reflecting the average cost of state plan private duty nursing or personal care services shall become effective on the later of the first day of the month of the member's twenty-first birthday or the first day of the month of the completed review.

(5) The revised waiver budget shall extend up to the first of the month following the member's twenty-fifth birthday and shall remain at the initially authorized amount for the member while aged 21 through 24.

c. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker or targeted case manager. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) “b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 4209C, IAB 1/2/19, effective 2/6/19; ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 5487C, IAB 3/10/21, effective 4/14/21]

441—83.3(249A) Application.

83.3(1) *Application for HCBS health and disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.3(2) *Application and services program limit.* The number of persons who may be approved for the HCBS health and disability waiver shall be subject to the number of members to be served as set forth in the federally approved HCBS health and disability waiver. The number of members to be served is set forth at the time of each five-year renewal of the waiver or in amendments to the waiver approved by the Centers for Medicare and Medicaid Services (CMS). When the number of applicants exceeds the number of members specified in the approved waiver, the applicant’s name shall be placed on a waiting list maintained by the bureau of long-term care.

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the applicant.

(3) A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(4) Once a payment slot is assigned, the county department office shall give written notice to the applicant. The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the department shall enter persons on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later.

(2) Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date a request as specified in 83.3(2)“a”(2) is received by the department.

(3) In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(4) Applicants who do not fall within the available slots shall have their application rejected, and their names shall be maintained on the waiting list. They shall be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program is maintained. The bureau of long-term care shall contact the county department office when a slot becomes available.

(5) Once a payment slot is assigned, the county department office shall give written notice to the person within five working days. The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

c. The county department office shall notify the bureau of long-term care within five working days of the receipt of an application and of any action on or withdrawal of an application.

83.3(3) Approval of application.

a. Applications for the HCBS health and disability waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal supplemental security income benefits.

(2) The application is pending because the department has not received information which is beyond the control of the client or the department.

(3) The application is pending due to the disability determination process performed through the department.

(4) The application is pending because a level of care determination has not been made although the required assessment has been submitted to the IME medical services unit.

(5) The application is pending because the required assessment has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, the application shall be denied.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations are completed.

c. An applicant must be given the choice between HCBS health and disability waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

e. A member may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the member is in a medical institution (hospital or nursing facility) or residential facility. Services may not be simultaneously reimbursed for the same time period as Medicaid or other Medicaid waiver services.

83.3(4) Effective date of eligibility.

a. Deeming of parental or spousal income and resources ceases and eligibility shall be effective on the date the income and resource eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

b. The effective date of eligibility for the health and disability waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs 83.3(4)“a” and “c” do not apply is the date on which the income eligibility and level of care determinations are completed.

c. Eligibility for persons covered under subparagraph 83.2(1)“c”(3) shall exist on the date the income and resource eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

d. Eligibility continues until the member has been in a medical institution for 120 consecutive days for other than respite care. Members who are inpatients in a medical institution for 120 or more consecutive days for other than respite care shall be terminated from health and disability waiver services and reviewed for eligibility for other Medicaid coverage groups. The member will be notified of that decision through Form 470-0602, Notice of Decision. If the member returns home before the effective date of the notice of decision and the member’s condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.3(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of health and disability waiver services or other Medicaid services, as applicable.

83.4(1) Maintenance needs of the individual. The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client’s total income.

83.4(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker or targeted case manager for health and disability waiver services, Medicaid shall make no payments to health and disability waiver service providers. However, Medicaid shall make payments to other medical vendors, as applicable.

83.4(3) Maintenance needs of spouse and other dependents. Rescinded IAB 4/9/97, effective 6/1/97. [ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the health and disability waiver shall be completed at least once every 12 months or when there is significant change in the person’s situation or condition.

A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current service plan meeting the requirements listed in rule 441—83.7(249A).

83.5(1) The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

83.5(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—83.6(249A) Allowable services. Services allowable under the health and disability waiver are homemaker, home health, adult day care, respite care, nursing, counseling, consumer-directed attendant care, interim medical monitoring and treatment, home and vehicle modification, personal emergency response system, home-delivered meals, nutritional counseling, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.34(249A).

[ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.7(249A) Service plan. A service plan shall be prepared for health and disability waiver members in accordance with 441—paragraph 90.4(1) “b.” Service plans for both children and adults shall be completed every 12 months or when there is significant change in the person’s situation or condition.

83.7(1) The service plan shall include the frequency of the health and disability waiver services and the types of providers who will deliver the services.

83.7(2) The service plan shall indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the member; and
- b. The financial management service selected by the member.

83.7(3) The service plan shall also list all nonwaiver Medicaid services.

83.7(4) The service plan shall identify a plan for emergencies and the supports available to the member in an emergency.

[ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4897C, IAB 2/12/20, effective 3/18/20]

441—83.8(249A) Adverse service actions.

83.8(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Needed services are not available or received from qualified providers.
- c. Service needs exceed the aggregate monthly costs established in 83.2(2) “b,” or are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.

83.8(2) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) “a,” “b,” “c,” “g,” or “h” apply.
- b. The costs of the health and disability waiver service for the person exceed the aggregate monthly costs established in 83.2(2) “b.”
- c. The member receives care in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability for 120 days in any one stay for purposes other than respite care.
- d. The member receives health and disability waiver services and the physical or mental condition of the member requires more care than can be provided in the member’s own home as determined by the designated case manager.
- e. Service providers are not available.

83.8(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.9(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the IME medical services unit by sending a letter requesting a review to the IME medical services unit. If dissatisfied with that decision, the applicant or recipient may file an appeal with the department.

[ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.10(249A) County reimbursement. Rescinded IAB 4/9/97, effective 6/1/97.

441—83.11(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.12 to 83.20 Reserved.

DIVISION II—HCBS ELDERLY WAIVER SERVICES

441—83.21(249A) Definitions.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Basic individual respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“Client participation” means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Interdisciplinary team” means a collection of persons with varied professional backgrounds who develop one plan of care to meet a client’s need for services.

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

“Medical institution” means a nursing facility which has been approved as a Medicaid vendor.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Service plan” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“Specialized respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“Third-party payments” means payments from an individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.
 [ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—83.22(249A) Eligibility. To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.22(1) Eligibility criteria. All of the following criteria must be met. The person must be:

a. Sixty-five years of age or older.
 b. A resident of the state of Iowa.
 c. Eligible for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2)“b” and 75.5(4)“c” shall be applied.

d. Certified as being in need of the intermediate or skilled level of care based, in part, on information submitted on the interRAI - Home Care (HC). The interRAI - Home Care (HC) is available on request from IME medical services unit and other supporting documentation as relevant. Copies of the completed interRAI - Home Care (HC) for an individual are available to that individual from the individual’s case manager or managed care organization.

(1) The assessment shall be completed when the person applies for waiver services, upon request to report a significant change in the person’s condition, and annually for reassessment of the person’s level of care. The IME medical services unit shall be responsible for determination of the initial level of care.

(2) The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

(3) Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

e. Determined to need services as described in subrule 83.22(2).

f. Rescinded IAB 10/11/06, effective 10/1/06.

g. For the consumer choices option as set forth in rule 441—subrule 78.37(16), residing in a living arrangement other than a residential care facility.

83.22(2) Need for services, service plan, and cost.

a. *Case management.* Consumers under the elderly waiver shall receive case management services from a provider qualified pursuant to rule 441—77.29(249A). Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. *Interdisciplinary team.* The case manager shall establish an interdisciplinary team for the consumer.

(1) *Composition.* The interdisciplinary team shall include the case manager and the consumer and, if appropriate, the consumer’s legal representative, family, service providers, and others directly involved in the consumer’s care.

(2) *Role.* The team shall identify:

1. The consumer’s need for services based on the consumer’s needs and desires.

2. Available and appropriate services to meet the consumer’s needs.

3. Health and safety issues for the consumer that indicate the need for an emergency plan, based on a risk assessment conducted before the team meeting.

4. Emergency backup support and a crisis response system to address problems or issues arising when support services are interrupted or delayed or when the consumer’s needs change.

c. *Service plan.* An applicant for elderly waiver services shall have a service plan developed by a qualified provider of case management services under the elderly waiver.

- (1) Services included in the service plan shall be appropriate to the problems and specific needs or disabilities of the consumer.
- (2) Services must be the least costly available to meet the service needs of the member.
- (3) The service plan must be completed before services are provided.
- (4) The service plan must be reviewed at least annually and when there is any significant change in the consumer's needs.

d. Content of service plan. The service plan shall include the following information based on the consumer's current assessment and service needs:

- (1) Observable or measurable individual goals.
- (2) Interventions and supports needed to meet those goals.
- (3) Incremental action steps, as appropriate.
- (4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.
- (5) The desired individual outcomes.
- (6) The identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.
- (7) Description of any restrictions on the consumer's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.
- (8) A list of all Medicaid and non-Medicaid services that the consumer received at the time of waiver program enrollment that includes:
 1. The name of the service provider responsible for providing the service.
 2. The funding source for the service.
 3. The amount of service that the consumer is to receive.
- (9) Indication of whether the consumer has elected the consumer choice option and, if so, the independent support broker and the financial management service that the consumer has selected.
- (10) The determination that the services authorized in the service plan are the least costly.
- (11) A plan for emergencies that identifies the supports available to the consumer in situations for which no approved service plan exists and which, if not addressed, may result in injury or harm to the consumer or other persons or in significant amounts of property damage. Emergency plans shall include:
 1. The consumer's risk assessment and the health and safety issues identified by the consumer's interdisciplinary team.
 2. The emergency backup support and crisis response system identified by the interdisciplinary team.
 3. Emergency, backup staff designated by providers for applicable services.

83.22(3) Providers—standards. Rescinded IAB 10/11/06, effective 10/1/06.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 5419C, IAB 2/10/21, effective 4/1/21]

441—83.23(249A) Application.

83.23(1) Application for HCBS elderly waiver. The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.23(2) Application for services. Rescinded IAB 12/6/95, effective 2/1/96.

83.23(3) Approval of application.

a. Applications for the elderly waiver program shall be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign the information submission tool specified in 83.22(1) “d,” indicating that the applicant has elected waiver services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.23(4) Effective date of eligibility.

a. The effective date of eligibility is the date on which the income eligibility and level of care determinations are completed.

b. Eligibility for persons whose income exceeds supplemental security income guidelines shall not exist until the persons require care in a medical institution for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins.

c. Eligibility continues until the consumer has been in a medical institution for 120 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.22(249A). Consumers who are inpatients in a medical institution for 120 or more consecutive days for other than respite care shall be terminated from elderly waiver services and reviewed for eligibility for other Medicaid coverage groups. The consumer will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the consumer’s condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.23(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.24(249A) Client participation. Persons must contribute their predetermined client participation to the cost of elderly waiver services.

83.24(1) Computation of client participation. Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client’s total income.

83.24(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments for elderly waiver service providers. However, Medicaid will make payments to other medical vendors.

441—83.25(249A) Redetermination. A complete redetermination of eligibility for elderly waiver services shall be done at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination shall contain the components listed in rule 441—83.27(249A).

83.25(1) The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

83.25(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

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

441—83.26(249A) Allowable services. Services allowable under the elderly waiver are case management, adult day care, emergency response system, homemaker, home health aide, nursing, respite care, chore, home-delivered meals, home and vehicle modification, mental health outreach,

transportation, nutritional counseling, assistive devices, senior companions, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.37(249A).

441—83.27(249A) Service plan. The service plan shall be completed jointly by the consumer, the elderly waiver case manager, and any other person identified by the consumer.

83.27(1) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the consumer; and
- b. The financial management service selected by the consumer.

83.27(2) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.28(249A) Adverse service actions.

83.28(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Except for respite care, the elderly waiver services are not needed on a regular basis.
- c. Service needs are not met by services provided.
- d. Needed services are not available or received from qualifying providers.
- e. Rescinded IAB 3/2/94, effective 3/1/94.

83.28(2) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “a,” “b,” “c,” “d,” “g,” or “h” apply.
- b. The client receives care in a hospital or nursing facility for 120 days in any one stay for purposes other than respite care.
- c. The client receives elderly waiver services and the physical or mental condition of the client requires more care than can be provided in the client’s own home as determined by the case manager and the interdisciplinary team.
- d. Service providers are not available.

83.28(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”
[ARC 3234C, IAB 8/2/17, effective 9/6/17; ARC 5419C, IAB 2/10/21, effective 4/1/21]

441—83.29(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.30(249A) Enhanced services. When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management shall cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person’s primary diagnosis will determine which services shall be used.

441—83.31(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.32 to 83.40 Reserved.

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

441—83.41(249A) Definitions.

“*AIDS*” means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control “Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome,” August 14, 1987, Vol. 36, No. 1S issue of “Morbidity and Mortality Weekly Report.”

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Basic individual respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“Client participation” means the amount of the recipient’s income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

“Deeming” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“Financial participation” means client participation and medical payments from a third party including veterans’ aid and attendance.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“HIV” means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

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

“Medical institution” means a nursing facility or hospital which has been approved as a Medicaid vendor.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.
2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Service plan” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).
3. Documentation submitted for review indicates that the member has:
 - a. A physician order for all skilled services.
 - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - c. An individualized care plan that identifies support needs.
 - d. Confirmation that skilled services are provided to the member.
 - e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
 - f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Third-party payments*” means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.
[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—83.42(249A) Eligibility. To be eligible for AIDS/HIV waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.42(1) Eligibility criteria. All of the following criteria must be met. The person must:

a. Be diagnosed by a physician as having AIDS or HIV infection.
b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital based, in part, on information submitted on a completed Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC), and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual’s case manager or managed care organization.

(1) The assessment as listed in 83.42(1)“b” shall be completed when the person applies for waiver services, upon request to report a significant change in the person’s condition, and annually for reassessment of the person’s level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care, and the IME medical services unit or a managed care organization will be responsible for annual redeterminations.

(3) AIDS/HIV waiver services shall not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under SSI, SSI-related, FMAP, or FMAP-related coverage groups; medically needy at hospital level of care; or a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

d. Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

e. Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

f. Have income which does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

g. For the consumer choices option as set forth in 441—subrule 78.38(9), not be living in a residential care facility.

83.42(2) Need for services.

a. The designated case manager shall review the assessment of the person’s need for waiver services and determine the availability and appropriateness of services. This review shall be based, in part, on information in the completed information submission tool designated in 83.42(1)“b” and other supporting documentation as relevant.

b. The total monthly cost of the AIDS/HIV waiver services shall not exceed the established aggregate monthly cost for level of care. The monthly cost of AIDS/HIV waiver services cannot exceed the established limit of \$1,876.80.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.43(249A) Application.

83.43(1) *Application for HCBS AIDS/HIV waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.43(2) *Application for services.* Rescinded IAB 12/6/95, effective 2/1/96.

83.43(3) *Approval of application.*

a. Applications for the HCBS AIDS/HIV waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information, which is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made although the completed assessment has been submitted to the IME medical services unit.

(3) Rescinded IAB 3/7/01, effective 5/1/01.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the consumer service plan are completed.

c. An applicant must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.43(4) *Effective date of eligibility.*

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—subrule 75.1(7) and rule 441—75.5(249A) do not apply is the date on which income and resource eligibility and level of care determinations are completed.

c. Eligibility for the waiver continues until the recipient has been in a medical institution for 120 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 120 or more consecutive days for other than respite care shall be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The recipient will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A) have been satisfied is the date on which the income eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

83.43(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.44(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

83.44(1) *Maintenance needs of the individual.* The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.44(2) *Limitation on payment.* If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

83.44(3) *Maintenance needs of spouse and other dependents.* Rescinded IAB 4/9/97, effective 6/1/97.

441—83.45(249A) Redetermination. A complete redetermination of eligibility for AIDS/HIV waiver services shall be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.42(249A). A redetermination shall include the components listed in rule 441—83.47(249A).

83.45(1) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

83.45(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

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

441—83.46(249A) Allowable services. Services allowable under the AIDS/HIV waiver are counseling, home health aide, homemaker, nursing care, respite care, home-delivered meals, adult day care, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.38(249A).

441—83.47(249A) Service plan. A service plan shall be prepared for AIDS/HIV waiver consumers in accordance with rule 441—130.7(234) except that service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.47(1) The service plan shall include the frequency of the AIDS/HIV waiver services and the types of providers who will deliver the services.

83.47(2) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the consumer; and
- b. The financial management service selected by the consumer.

83.47(3) Service plans for consumers aged 20 or under must be developed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

83.47(4) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.48(249A) Adverse service actions.

83.48(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.
- c. Service needs exceed the aggregate monthly costs established in 83.42(2) "b" or cannot be met by the services provided under the waiver.
- d. Needed services are not available from qualified providers.

83.48(2) Termination. Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “a,” “b,” “c,” “d,” “g,” or “h” apply.
- b. The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in 83.42(2) “b.”
- c. The client receives care in a hospital or nursing facility for 120 days or more in any one stay for purposes other than respite care.
- d. The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client’s own home as determined by the service worker.
- e. Service providers are not available.

83.48(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”
[ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.49(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).
[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.50(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.
These rules are intended to implement Iowa Code section 249A.4.

441—83.51 to 83.59 Reserved.

DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES

441—83.60(249A) Definitions.

“*Adaptive*” means age-appropriate skills related to taking care of one’s self and one’s ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

“*Adult*” means a person with an intellectual disability aged 18 or over.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Behavior*” means skills related to regulating one’s own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“*Case management services*” means those services established pursuant to Iowa Code chapter 225C.

“*Child*” means a person with an intellectual disability aged 17 or under.

“*Client participation*” means the posteligibility amount of the consumer’s income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

“*Counseling*” means face-to-face mental health services provided to the consumer and caregiver by a qualified intellectual disability professional (QIDP) to facilitate home management of the consumer and prevent institutionalization.

“*Deemed status*” means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

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

“Direct service” means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

“Fiscal accountability” means the development and maintenance of budgets and independent fiscal review.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Health” means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

“Immediate jeopardy” means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

“Intellectual disability” means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) which shall be made only when the onset of the person’s condition was during the developmental period and shall be based on an assessment of the person’s intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person’s adaptive skills. The diagnosis shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published by the American Psychiatric Association.

“Intermediate care facility for persons with an intellectual disability (ICF/ID)” means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Intermittent supported community living service” means supported community living service provided not more than 52 hours per month.

“Maintenance needs” means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

“Managed care” means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

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

“Medical assessment” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“Medical institution” means a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“Medical intervention” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“Natural supports” means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

“Organization” means the entity being certified.

“Organizational outcome” means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

“Outcome” means an action or event that follows as a result or consequence of the provision of a service or support.

“Procedures” means the steps to be taken to implement a policy.

“Process” means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

“Qualified intellectual disability professional” means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.
6. A psychologist with a master’s degree in psychology from an accredited school.
7. A social worker with a graduate degree from a school of social work, accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.
8. A professional recreation staff member with a bachelor’s degree in recreation or in a specialty area such as art, dance, music or physical education.
9. A professional dietitian who is eligible for registration by the American Dietetics Association.
10. A human services professional who must have at least a bachelor’s degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling and psychology.

“Related condition” means a severe, chronic disability that meets all the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability and requires treatment or services similar to those required for a person with an intellectual disability.
2. It is manifested before the age of 22.
3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three or more of the following areas of major life activity:

- Self-care.
- Understanding and use of language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for independent living.

“*Service plan*” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“*SIS assessment*” means the Supports Intensity Scale® assessment developed and licensed by the American Association on Intellectual and Developmental Disabilities for use in the assessment of the support and service needs of individuals.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Staff*” means a person under the direction of the organization to perform duties and responsibilities of the organization.

“*Third-party payments*” means payments from an attorney, individual, institution, corporation, insurance company, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of Medicaid.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—83.61(249A) Eligibility. To be eligible for HCBS intellectual disability waiver services a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

83.61(1) Eligibility criteria. All of the following criteria must be met. The person must:

a. Have a diagnosis of intellectual disability as defined in rule 441—83.60(249A). The diagnosis shall be initially established and recertified as follows:

Age	Initial application to HCBS intellectual disability waiver program	Recertification for persons with a diagnosis of moderate, severe or profound level of severity	Recertification for persons with a diagnosis of mild or unspecified level of severity
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of intellectual disability as defined in rule 441—83.60(249A)	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every six years and when a significant change occurs	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every three years and when a significant change occurs
18 years and above	Current psychological documentation substantiating a diagnosis of intellectual disability if the last testing date was (1) more than six years ago for an applicant with a diagnosis of mild or unspecified severity, or (2) more than ten years ago for an applicant with a diagnosis of moderate, severe or profound level of severity	Psychological documentation substantiating a diagnosis of intellectual disability made since the member reached 22 years of age	Psychological documentation substantiating a diagnosis of intellectual disability every six years and whenever a significant change occurs

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.

c. Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/ID. The IME medical services unit shall be responsible for the initial approval, and the IME medical services unit or a managed care organization will be responsible for the annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

d. Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

e. Have service needs that can be met by this waiver program. At a minimum, a consumer must receive one billable unit of service per calendar quarter under this program.

f. Have a service plan completed annually and approved by the department in accordance with rule 441—83.67(249A).

g. For individual supported employment and long-term job coaching services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Not reside in a medical institution.

(4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

h. For small-group supported employment services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

i. For prevocational services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

j. Choose HCBS intellectual disability waiver services rather than ICF/ID services.

k. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical

emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.

l. Be assigned an HCBS intellectual disability payment slot pursuant to subrule 83.61(4).

m. For residential-based supported community living services, meet all of the following additional criteria:

(1) Be less than 18 years of age.

(2) Be preapproved as appropriate for residential-based supported community living services by the bureau of long-term care. Requests for approval shall be submitted in writing to the DHS Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, and shall include the following:

1. Social history;

2. Case history that includes previous placements and service programs;

3. Medical history that includes major illnesses and current medications;

4. Current psychological evaluations and consultations;

5. Summary of all reasonable and appropriate service alternatives that have been tried or considered;

6. Any current court orders in effect regarding the child;

7. Any legal history;

8. Whether the child is at risk of out-of-home placement or the proposed placement would be less restrictive than the child's current placement for services;

9. Whether the proposed placement would be safe for the child and for other children living in that setting; and

10. Whether the interdisciplinary team is in agreement with the proposed placement.

(3) Either:

1. Be residing in an ICF/ID;

2. Be at risk of ICF/ID placement, as documented by an interdisciplinary team assessment pursuant to paragraph 83.61(2) "a"; or

3. Be a child whose long-term placement outside the home is necessary because continued stay in the home would be a detriment to the health and welfare of the child or the family, and all service options to keep the child in the home have been reviewed by an interdisciplinary team, as documented in the service file.

n. For day habilitation, be 16 years of age or older.

o. For the consumer choices option as set forth in 441—subrule 78.41(5), not be living in a residential care facility.

83.61(2) Need for services.

a. Applicants currently receiving Medicaid case management shall have the applicable staff coordinate with the department to arrange completion of Form 470-4694 for children under the age of five and, for all others, a SIS assessment.

b. Applicants not receiving services as set forth in paragraph 83.61(2) "a" shall have a department service worker or case manager:

(1) Arrange for completion of Form 470-4694 for children under the age of five and, for all others, a SIS assessment for the initial level of care determination;

(2) Establish an initial interdisciplinary team for HCBS intellectual disability waiver services; and

(3) With the initial interdisciplinary team, identify the applicant's needs and desires as well as the availability and appropriateness of services.

c. Applicants meeting other eligibility criteria who do not have a Medicaid case manager shall be referred to a Medicaid case manager.

d. Services shall not exceed the number of maximum units established for each service.

e. The cost of services shall not exceed unit expense maximums. Requests shall only be reviewed for funding needs exceeding the supported community living service unit cost maximum. Requests require special review by the department and may be denied as not cost-effective.

f. The case manager shall coordinate with the department for completion of Form 470-4694 for children under the age of five and, for all others, to arrange a SIS assessment for the initial level of care determination within 30 days from the date of the HCBS application unless the case manager can document difficulty in locating information necessary to arrange the assessment or other circumstances beyond the case manager's control.

g. At initial enrollment, the case manager shall establish an interdisciplinary team for each applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services. The Medicaid case manager shall complete an annual review thereafter. The following criteria shall be used for the initial and ongoing identification of need for services:

(1) The assessment shall be based on the results of the most recent Form 470-4694 for children under the age of five and, for all others, the SIS assessment or of the SIS contractor's off-year review.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall be approved (signed and dated) by the designee of the bureau of long-term care. The service worker, department QIDP, or Medicaid case manager shall attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance shall provide a rationale for requesting supported community living beyond intermittent. The rationale shall contain sufficient information for the designee to make a decision regarding the need for supported community living beyond intermittent.

h. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)“b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

83.61(3) HCBS intellectual disability waiver program limit. The number of persons receiving HCBS intellectual disability waiver services in the state shall be limited to the number of payment slots provided in the HCBS intellectual disability waiver approved by the Centers for Medicare and Medicaid Services (CMS). The department shall make a request to CMS to adjust the program limit as deemed necessary.

a. The payment slots are available on a statewide basis. These slots shall be available based on the prioritized need of an applicant pursuant to subrule 83.61(4).

b. When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person's name will be put on a waiting list shall be sent to the person by the department.

83.61(4) Securing a payment slot. The department shall determine if a payment slot is available for each applicant for the HCBS intellectual disability waiver.

a. A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(1) Once a payment slot is assigned, the department shall give written notice to the applicant.

(2) The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the applicant shall be placed on a statewide priority waiting list. The department shall assess each applicant to determine the applicant's priority need. The assessment shall be made for all applicants who are on a waiting list maintained by the state or a county on September 30, 2011, and for all new applications received on or after October 1, 2011.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion shall be placed on the priority waiting list based on the total number of criteria in subparagraph 83.61(4) "b"(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of criteria in subparagraph 83.61(4) "b"(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria shall be placed lower on the waiting list than the applicants meeting urgent need criteria, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(6) Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the local department office and request that a new assessment be completed. The outcome of the assessment shall determine placement on the waiting list as directed in this subrule.

c. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department shall give written notice to the person within five working days.

(2) The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 5487C, IAB 3/10/21, effective 4/14/21]

441—83.62(249A) Application.

83.62(1) *Application for HCBS intellectual disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.62(2) Rescinded IAB 6/5/96, effective 8/1/96.

83.62(3) *Approval of application.*

a. Applications for the HCBS intellectual disability waiver program shall be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant shall be given the choice between HCBS waiver services and ICF/ID care. The case manager or worker shall have the consumer or legal representative indicate the consumer's choice of care.

d. HCBS intellectual disability waiver services provided before eligibility for the waiver is approved shall not be reimbursed by the HCBS waiver program.

e. Services provided when the person is a consumer of group foster care services or is an inpatient in a medical institution shall not be reimbursed.

f. HCBS intellectual disability waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

g. Rescinded IAB 5/6/09, effective 7/1/09.

83.62(4) *Effective date of eligibility.*

a. Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

b. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

c. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in rule 441—83.61(249A) and when the eligibility factor set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A) have been satisfied.

d. Eligibility continues until the consumer fails to meet eligibility criteria listed in rule 441—83.61(249A). Consumers who are inpatients in a medical institution for 120 consecutive days shall receive a review by the interdisciplinary team to determine additional inpatient needs for possible

termination from the HCBS program. Consumers shall be reviewed for eligibility under other Medicaid coverage groups. The consumer or legal representative shall participate in the review and receive formal notification of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

e. Eligibility and service reimbursement are effective through the last day of the month of the previous annual service plan staffing meeting and the corresponding long-term care need determination.

83.62(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.63(249A) Client participation. Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

83.63(1) Computation of client participation. Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.63(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

441—83.64(249A) Redetermination. A redetermination of nonfinancial eligibility for HCBS intellectual disability waiver services shall be completed at least once every 12 months. In years in which a SIS assessment is not completed for an individual five years of age or older, the SIS contractor shall conduct a review in collaboration with the case manager, documenting any changes in the member's functional status since the previous SIS or other full assessment. Form 470-4694 shall be completed annually for children under the age of five.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

83.64(1) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

83.64(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.65(249A) Rescinded IAB 6/5/96, effective 8/1/96.

441—83.66(249A) Allowable services. Services allowable under the HCBS intellectual disability waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modification, supported employment, consumer-directed attendant care, interim medical monitoring and treatment, transportation, adult day care, day habilitation, prevocational services, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.41(249A).

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

441—83.67(249A) Service plan. A service plan shall be prepared for each HCBS intellectual disability waiver consumer.

83.67(1) Development. The service plan shall be developed by the interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager or service worker, service providers, and others directly involved.

83.67(2) Retention. The service plan shall be stored by the case manager for a minimum of three years.

83.67(3) Interdisciplinary team meeting. The interdisciplinary team meeting shall be conducted before the current service plan expires.

83.67(4) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
 - (1) The consumer's living environment at the time of waiver enrollment.
 - (2) The number of hours per day of on-site staff supervision needed by the consumer.
 - (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of the consumer's rights including, but not limited to:
 - (1) Maintenance of personal funds.
 - (2) Self-administration of medications.
- d. The name of the service provider responsible for providing each service.
- e. The service funding source.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

i. For members receiving daily supported community living, day habilitation or adult day care: the following standard scores from the most recently completed SIS assessment:

- (1) Score on subsection 1A: Exceptional Medical Support Needs.
- (2) Score on subsection 1B: Exceptional Behavioral Support Needs.
- (3) Sum total of standard scores on the following subsections:
 - 1. Subsection 2A: Home Living Activities;
 - 2. Subsection 2B: Community Living Activities;
 - 3. Subsection 2E: Health and Safety Activities; and
 - 4. Subsection 2F: Social Activities.

83.67(5) Documentation. The Medicaid case manager shall ensure that the consumer's case file contains the consumer's service plan and documentation supporting the diagnosis of mental retardation.

83.67(6) Approval of plan. The plan shall be approved through the Individualized Services Information System (ISIS). Services shall be entered into ISIS based on the service plan.

- a. Services must be authorized and entered into ISIS before the plan implementation date.
- b. The department has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan unless the parties mutually agree to extend that time frame.

c. If the department and the service worker or case manager are unable to agree on the terms of the services or service cost within 10 days, the department has final authority regarding the services and service cost.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 3481C, IAB 12/6/17, effective 12/1/17; ARC 3790C, IAB 5/9/18, effective 6/13/18]

441—83.68(249A) Adverse service actions.

83.68(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The applicant is not eligible for the services.
- b. Service needs exceed the service unit or reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. No HCBS intellectual disability waiver service is identified in the applicant's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.
- g. Completion or receipt of required documents by the department for the HCBS program applicant has not occurred.

83.68(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph “a” or “b,” apply.

83.68(3) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2) paragraph “d,” “g,” or “h,” apply.
- b. Needed services are not available or received from qualifying providers.
- c. No HCBS intellectual disability waiver service is identified in the member's annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the department for the HCBS program consumer has not occurred.
- g. The consumer receives services from other Medicaid waiver programs.
- h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

441—83.69(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.70(249A) County reimbursement. Rescinded ARC 0191C, IAB 7/11/12, effective 7/1/12.

441—83.71(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

441—83.72(249A) Rent subsidy program. Members in the HCBS intellectual disability waiver program may be eligible for a rent subsidy. See 265—Chapter 24.

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.73 to 83.80 Reserved.

DIVISION V—BRAIN INJURY WAIVER SERVICES

441—83.81(249A) Definitions.

“*Adaptive*” means age appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“*Adult*” means a person with a brain injury aged 18 years or over.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

“*Assessment*” means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, strengths, abilities, desires and goals.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Behavior*” means skills related to regulating one’s own behavior including coping with demands from others, making choices, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“*Brain injury*” means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person’s physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

- Malignant neoplasms of brain, cerebrum.
- Malignant neoplasms of brain, frontal lobe.
- Malignant neoplasms of brain, temporal lobe.
- Malignant neoplasms of brain, parietal lobe.
- Malignant neoplasms of brain, occipital lobe.
- Malignant neoplasms of brain, ventricles.
- Malignant neoplasms of brain, cerebellum.
- Malignant neoplasms of brain, brain stem.
- Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.
- Malignant neoplasms of brain, cerebral meninges.
- Malignant neoplasms of brain, cranial nerves.
- Secondary malignant neoplasm of brain.
- Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.
- Benign neoplasm of brain and other parts of the nervous system, brain.
- Benign neoplasm of brain and other parts of the nervous system, cranial nerves.
- Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.
- Encephalitis, myelitis and encephalomyelitis.
- Intracranial and intraspinal abscess.
- Anoxic brain damage.
- Subarachnoid hemorrhage.
- Intracerebral hemorrhage.
- Other and unspecified intracranial hemorrhage.
- Occlusion and stenosis of precerebral arteries.
- Occlusion of cerebral arteries.
- Transient cerebral ischemia.
- Acute, but ill-defined, cerebrovascular disease.
- Other and ill-defined cerebrovascular diseases.
- Fracture of vault of skull.
- Fracture of base of skull.
- Other and unqualified skull fractures.
- Multiple fractures involving skull or face with other bones.
- Concussion.
- Cerebral laceration and contusion.
- Cerebral edema.
- Cerebral palsy.

Subarachnoid, subdural, and extradural hemorrhage following injury.

Other and unspecified intracranial hemorrhage following injury.

Intracranial injury of other and unspecified nature.

Poisoning by drugs, medicinal and biological substances.

Toxic effects of substances.

Effects of external causes.

Drowning and nonfatal submersion.

Asphyxiation and strangulation.

Child maltreatment syndrome.

Adult maltreatment syndrome.

Status epilepticus.

“Case management services” means those services established pursuant to Iowa Code chapter 225C.

“Child” means a person with a brain injury aged 17 years or under.

“Client participation” means the amount of the consumer’s income that the person must contribute to the cost of brain injury waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

“Deemed status” means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

“Department” means the Iowa department of human services.

“Direct service” means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

“Fiscal accountability” means the development and maintenance of budgets and independent fiscal review.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Health” means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

“Immediate jeopardy” means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Intermittent supported community living service” means supported community living service provided from one to three hours a day for not more than four days a week.

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

“Medical assessment” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“Medical institution” means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“Medical intervention” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“Natural supports” means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Organization” means the entity being certified.

“Organizational outcome” means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

“Outcome” means an action or event that follows as a result or consequence of the provision of a service or support.

“Procedures” means the steps to be taken to implement a policy.

“Process” means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

“Qualified brain injury professional” means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years’ experience working with people living with a brain injury: a psychologist; psychiatrist; physician; physician assistant; registered nurse; certified teacher; licensed clinical social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in human services, social work, psychology, sociology, or public health or rehabilitation services plus 4,000 hours of direct experience with people living with a brain injury.

“Service coordination” means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

“Service plan” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- a. A physician order for all skilled services.

- b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

- c. An individualized care plan that identifies support needs.

- d. Confirmation that skilled services are provided to the member.

- e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

- f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Staff*” means a person under the direction of the organization to perform duties and responsibilities of the organization.

“*Third-party payments*” means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4792C, IAB 12/4/19, effective 1/8/20]

441—83.82(249A) Eligibility. To be eligible for brain injury waiver services a consumer must meet eligibility criteria and be determined to need a service allowable under the program.

83.82(1) Eligibility criteria. All of the following criteria must be met. The person must:

- a. Have a diagnosis of brain injury.
- b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups or be eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution.
- c. Be at least one month of age.
- d. Be a U.S. citizen and Iowa resident.
- e. Rescinded IAB 7/11/01, effective 7/1/01.
- f. Be determined by the IME medical services unit as in need of intermediate care facility for persons with an intellectual disability (ICF/ID), skilled nursing, or ICF level of care based on information submitted on a completed Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over, the most recent version of the Mayo-Portland Adaptability Inventory (MPAI), and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC), and the interRAI - Home Care (HC), Form 470-4694, and Form 470-5572, the Mayo-Portland Adaptability Inventory (MPAI), are available on request from the member’s managed care organization or the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual’s case manager or managed care organization.
- g. Be assessed by the IME medical services unit as able to live in a home- or community-based setting where all medically necessary service needs can be met within the scope of this waiver.
- h. At a minimum, receive a waiver service each quarter in addition to case management.
- i. Choose HCBS.
- j. To be eligible for interim medical monitoring and treatment services the consumer must be:
 - (1) Under the age of 21;
 - (2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);
 - (3) Residing in the consumer’s family home or foster family home; and
 - (4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.
- k. Receive services in a community, not an institutional, setting.
- l. Be assigned a state payment slot within the yearly total approved by the Centers for Medicare and Medicaid Services.
- m. For the consumer choices option as set forth in rule 441—subrule 78.43(15), not be living in a residential care facility.

- n.* For individual supported employment and long-term job coaching services:
- (1) Be at least 16 years of age.
 - (2) The services must not be available to the member through one of the following:
 1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or
 2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
 - (3) Not reside in a medical institution.
 - (4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in this outcome.
- o.* For small-group supported employment services:
- (1) Be at least 16 years of age.
 - (2) The services must not be available to the member through one of the following:
 1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or
 2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
 - (3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.
 - (4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.
 - (5) Not reside in a medical institution.
- p.* For prevocational services:
- (1) Be at least 16 years of age.
 - (2) The services must not be available to the member through one of the following:
 1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or
 2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
 - (3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in community employment.
 - (4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive prevocational services was made.

83.82(2) *Need for services.*

- a.* The applicant shall have a service plan approved by the department that is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed before services provision and annually thereafter. The case manager shall establish the interdisciplinary team for the applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services using the following criteria:
- (1) The assessment shall be based, in part, on information provided to the IME medical services unit.
 - (2) Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid state services so as not to replace or duplicate those services.
 - (3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall not be approved until a home health provider has made a request to cover the service through all nonwaiver Medicaid services.
 - (4) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the service plan. The rationale must contain sufficient information for the bureau's designee to make a decision regarding the need for supported community living beyond intermittent.

b. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)“b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

c. The consumer shall access, if a child, all other services for which the person is eligible and which are appropriate to meet the person’s needs as a precondition of eligibility for the HCBS BI waiver.

83.82(3) *HCBS brain injury (BI) waiver program limit for persons requiring the ICF/MR level of care.* Rescinded IAB 7/11/01, effective 7/1/01.

83.82(4) *Securing a state payment slot.*

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available for all new applicants for the HCBS BI waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no payment slot is available, the department shall enter the applicant on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date the applicant requests HCBS BI program services.

(2) In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

c. Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

d. Applicants who currently reside in a community-based neurobehavioral rehabilitation residential setting, an intermediate care facility for persons with an intellectual disability (ICF/ID), a skilled nursing facility, or an ICF and have resided in that setting for six or more months may request a reserved capacity slot through the brain injury waiver.

(1) Applicants shall be allocated a reserved capacity slot on the basis of the date the request is received by the income maintenance worker or the waiver slot manager.

(2) In the event that more than one request for a reserved capacity slot is received at one time, applicants shall be allocated the next available reserved capacity slot on the basis of the month of birth, January being month one and the lowest number.

(3) Persons who do not fall within the available reserved capacity slots shall have their names maintained on the reserved capacity slot waiting list. As reserved capacity slots become available at the beginning of the next waiver year, persons shall be selected from the reserved capacity slot waiting list to utilize the number of approved reserved capacity slots based on their order on the waiting list.

e. The department shall reserve a set number of funding slots each waiver year for emergency need for all applicants who are on the waiting list maintained by the state on July 1, 2019, and for all new applications received on or after July 1, 2019. Applicants may request an emergency need reserved capacity slot by submitting the completed Home- and Community-Based Services (HCBS) Brain Injury Waiver Emergency Need Assessment, Form 470-5583, to the IME medical services unit.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter, and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion shall be placed on the emergency reserved capacity priority waiting list based on the total number of criteria in subparagraph 83.82(4) "e"(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of criteria in subparagraph 83.82(4) "e"(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria shall remain on the waiting list, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(6) Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the local department office and request that a new emergency needs assessment be completed. The outcome of the assessment shall determine placement on the waiting list as directed in this subrule.

f. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department shall give written notice to the person within five working days.

(2) The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 4792C, IAB 12/4/19, effective 1/8/20; ARC 4974C, IAB 3/11/20, effective 4/15/20; ARC 5487C, IAB 3/10/21, effective 4/14/21]

441—83.83(249A) Application.

83.83(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.83(2) *Approval of application for eligibility.*

a. Applications for the determination of ability of the consumer to have all medically necessary service needs met within the scope of this waiver shall be initiated on behalf of the consumer and with the consumer's consent or with the consent of the consumer's legal representative by the discharge planner of the medical facility where the consumer resides at the time of application or the case manager. The discharge planner or case manager shall provide to the IME medical services unit all appropriate information needed regarding all the medically necessary service needs of the consumer. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the IME medical services unit shall inform the discharge planner or case manager on behalf of the consumer or the consumer's legal representative and send to the income maintenance worker a copy of the decision as to whether all of the consumer's service needs can be met in a home- or community-based setting.

b. Eligibility for the HCBS BI waiver shall be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions shall be mailed or given to the consumer or the consumer's legal representative on the date when each eligibility determination is completed.

c. An applicant shall be given the choice between waiver services and institutional care. The applicant or legal representative shall sign the applicable information submission tool listed in paragraph 83.82(1) "*f*," indicating that the applicant has elected home- and community-based services. This shall be arranged by the medical facility discharge planner or case manager.

d. The medical facility discharge planner, if there is one involved, shall contact the consumer's managed care organization or the designated case manager to initiate development of the consumer's service plan and initiation of waiver services.

e. HCBS BI waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

f. HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services.

g. The Medicaid case manager shall establish an HCBS BI waiver interdisciplinary team for each consumer and, with the team, identify the consumer's "need for service" based on the consumer's needs and desires as well as the availability and appropriateness of services.

83.83(3) Effective date of eligibility.

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.82(249A). Consumers who return to inpatient status in a medical institution for more than 120 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the brain injury waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.83(4) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.84(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a predetermined participation amount to the cost of brain injury waiver services.

83.84(1) Computation of client participation. Client participation shall be computed by deducting an amount for the maintenance needs of the consumer which is 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.84(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific brain injury waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.85(249A) Redetermination. A complete financial redetermination of eligibility for brain injury waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination shall contain the components listed in rule 441—83.82(249A).

441—83.86(249A) Allowable services. Services allowable under the brain injury waiver are case management, respite, personal emergency response, supported community living, behavioral programming, family counseling and training, home and vehicle modification, specialized medical equipment, prevocational services, transportation, supported employment, adult day care, consumer-directed attendant care, interim medical monitoring and treatment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.43(249A).

441—83.87(249A) Service plan. A service plan shall be prepared and utilized for each HCBS BI waiver consumer. The service plan shall be developed by an interdisciplinary team, which includes the

consumer, and, if appropriate, the legal representative, consumer's family, case manager, providers, and others directly involved. The service plan shall be stored by the case manager for a minimum of three years. The service plan staffing shall be conducted before the current service plan expires.

83.87(1) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
 - (1) The consumer's living environment at the time of waiver enrollment.
 - (2) The number of hours per day of on-site staff supervision needed by the consumer.
 - (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of a consumer's rights including, but not limited to:
 - (1) Maintenance of personal funds.
 - (2) Self-administration of medications.
- d. The names of all providers responsible for providing all services.
- e. All service funding sources.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.87(2) Use of nonwaiver services. Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. Service plans for members aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager shall attach a written request for a variance from the limitation on supported community living to intermittent.

83.87(3) Annual assessment. The IME medical services unit shall assess the member annually and certify the member's need for long-term care services. The IME medical services unit shall be responsible for determining the level of care based on the completed information submission tool listed in paragraph 83.82(1) "f" and other supporting documentation as relevant.

a. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

b. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.87(4) Service file. The Medicaid case manager must ensure that the consumer service file contains the consumer's service plan.

a. to d. Rescinded IAB 8/7/02, effective 10/1/02.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.88(249A) Adverse service actions.

83.88(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The consumer is not eligible for the services because all of the medically necessary service needs cannot be met in a home- or community-based setting.
- b. Service needs exceed the service unit or reimbursement maximums.
- c. Service needs are not met by the services provided.

- d. Needed services are not available or received from qualifying providers.
- e. The brain injury waiver service is not identified in the consumer's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.
- g. The consumer receives services from other Medicaid waiver providers.
- h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

83.88(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph “a” or “b,” apply.

83.88(3) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “d,” “g,” or “h,” apply.
- b. Needed services are not available or received from qualifying providers.
- c. The brain injury waiver service is not identified in the consumer's annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the department or the medical facility discharge planner for the brain injury waiver service consumer has not occurred.
- g. The consumer receives services from other Medicaid providers.
- h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

441—83.89(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).
[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.90(249A) County reimbursement. Rescinded ARC 0191C, IAB 7/11/12, effective 7/1/12.

441—83.91(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.
These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.92 to 83.100 Reserved.

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

441—83.101(249A) Definitions.

“*Adaptive*” means age-appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“*Adult*” means a person with a physical disability aged 18 years to 64 years.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

“*Assessment*” means the review of the consumer's current functioning in regard to the consumer's situation, needs, strengths, abilities, desires and goals.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Behavior*” means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“Client participation” means the amount of the consumer’s income that the person must contribute to the cost of physical disability waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

“Department” means the Iowa department of human services.

“Guardian” means a guardian appointed in probate court for an adult.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

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

“Medical institution” means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Physical disability” means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

“Service plan” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- a. A physician order for all skilled services.

- b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

- c. An individualized care plan that identifies support needs.

- d. Confirmation that skilled services are provided to the member.

- e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

- f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“Third-party payments” means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

“*Waiver year*” means a 12-month period commencing on April 1 of each year.
 [ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—83.102(249A) Eligibility. To be eligible for physical disability waiver services, a consumer must meet eligibility criteria set forth in subrule 83.102(1) and be determined to need a service allowable under the program per subrule 83.102(2).

83.102(1) Eligibility criteria. All of the following criteria must be met. The person must:

- a. Have a physical disability.
- b. Be blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act or the disability guidelines for the Medicaid employed people with disabilities coverage group.
- c. Be ineligible for the HCBS intellectual disability waiver.
- d. Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so, or have a parent or guardian named by probate court, or attorney in fact under a durable power of attorney for health care who will take this responsibility on behalf of the consumer.
- e. Be eligible for Medicaid under 441—Chapter 75.
- f. Be aged 18 years to 64 years.
- g. Rescinded IAB 2/7/01, effective 2/1/01.
- h. Be in need of skilled nursing or intermediate care facility level of care based on information submitted on a completed interRAI - Pediatric Home Care (PEDS-HC) for those aged 18 to 20 or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. The interRAI - Pediatric Home Care (PEDS-HC) and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual’s case manager or managed care organization.

(1) Initial decisions on level of care shall be made for the department by the IME medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

(2) Adverse decisions by the IME medical services unit may be appealed to the department pursuant to 441—Chapter 7.

- i. Choose HCBS.
- j. Use a minimum of one unit of service per calendar quarter under this program.
- k. For the consumer choices option as set forth in 441—subrule 78.46(6), not be living in a residential care facility.

83.102(2) Need for services.

a. The applicant shall have a service plan which is developed by the applicant and a department service worker. The plan must be completed and approved before service provision.

(1) The designated case manager shall identify the need for service based on the needs of the applicant, as documented in the information submission tool listed in 83.102(1)“h,” as well as the availability and appropriateness of services.

(2) The service worker shall have a face-to-face visit with the member at least annually.

b. The total cost of physical disability waiver services, excluding the cost of home and vehicle modifications, shall not exceed \$705.84 per month.

83.102(3) Slots. The total number of persons receiving HCBS physical disability waiver services in the state shall be limited to the number provided in the waiver approved by the Secretary of the U.S. Department of Health and Human Services. These slots shall be available on a first-come, first-served basis.

83.102(4) County payment slots for persons requiring the ICF/MR level of care. Rescinded IAB 10/6/99, effective 10/1/99.

83.102(5) Securing a slot.

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a slot is available for all new applicants for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no slot is available, the department shall enter applicants on the HCBS physical disabilities waiver waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added on the basis of the date the applicant requests HCBS physical disability program services. In the event that more than one application is received on the same day, applicants shall be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

83.102(6) *Securing a county payment slot.* Rescinded IAB 10/6/99, effective 10/1/99.

83.102(7) *HCBS physical disability waiver waiting list.* When services are denied because the limit on the number of slots is reached, a notice of decision denying service based on the limit and stating that the person's name shall be put on a waiting list shall be sent to the person by the department.

[**ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1445C**, IAB 4/30/14, effective 7/1/14; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.103(249A) Application.

83.103(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed. Applications for this program may only be filed on or after April 1, 1999.

83.103(2) *Approval of application for eligibility.*

a. Applications for this waiver shall be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application.

(1) The discharge planner shall contact the member's managed care organization or designated case manager to arrange for completion of the appropriate information submission tool as listed in paragraph 83.102(1) "h."

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the discharge planner of the IME medical services unit's decision.

b. Applications for this waiver shall be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community.

(1) The applicant's managed care organization or the designated case manager shall arrange for the completion of the appropriate information submission tool as listed in paragraph 83.102(1) "h" and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care.

c. Eligibility for this waiver shall be effective as of the date when both the eligibility criteria in subrule 83.102(1) and need for services in subrule 83.102(2) have been established. Decisions shall be mailed or given to the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on the date when each eligibility determination is completed.

d. An applicant shall be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney for health care shall sign the information submission tool, indicating that the applicant has elected home- and community-based services.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall cooperate with the designated case manager in the development of the service plan prior to the start of services.

f. HCBS physical disability waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

g. HCBS physical disability waiver services are not available in conjunction with other HCBS waiver programs. The consumer may also receive in-home health-related care service if eligible for that program.

83.103(3) Effective date of eligibility.

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1) and when the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in subrule 83.102(1). Consumers who return to inpatient status in a medical institution for more than 120 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the physical disability waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.103(4) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the institutional level of care requirement as determined by the IME medical services unit or an appeal decision shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for a prior institutionalization shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.104(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a client participation amount to the cost of physical disability waiver services.

83.104(1) Computation of client participation. Client participation shall be computed by deducting a maintenance needs allowance equal to 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.104(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific physical disability waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.105(249A) *Redetermination.* A complete financial redetermination of eligibility for the physical disability waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.102(249A). A redetermination shall contain the components listed in rule 441—83.102(249A).

441—83.106(249A) *Allowable services.* The services allowable under the physical disability waiver are consumer-directed attendant care, home and vehicle modification, personal emergency response system, transportation, specialized medical equipment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.46(249A).

441—83.107(249A) *Individual service plan.* An individualized service plan shall be prepared and used for each HCBS physical disability waiver consumer. The service plan shall be developed and approved by the consumer, the consumer's interdisciplinary team and the designated case manager prior to services beginning and payment being made to the provider.

83.107(1) *Information in plan.* The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. The name of all providers responsible for providing all services.
- c. All service funding sources.
- d. The amount of the service to be received by the consumer.
- e. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- f. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.107(2) *Annual assessment.* The IME medical services unit or a managed care organization shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1) "h" and the appeal process at rule 441—83.109(249A), based on the appropriate information submission tool as listed in paragraph 83.102(1) "h" and other supporting documentation as relevant.

a. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

b. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.107(3) *Case file.* Rescinded IAB 8/7/02, effective 10/1/02.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.108(249A) *Adverse service actions.*

83.108(1) *Denial.* An application for services shall be denied when it is determined by the department that:

- a. All of the medically necessary service needs cannot be met in a home- or community-based setting.
- b. Service needs exceed the reimbursement maximums.

- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. The physical disability waiver service is not identified in the consumer's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.
- g. The consumer receives services from other Medicaid waiver providers.
- h. The consumer or legal representative requests termination from the services.

83.108(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph “a” or “b,” apply.

83.108(3) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “d,” “g,” or “h,” apply.
- b. Needed services are not available or received from qualifying providers.
- c. The physical disability waiver service is not identified in the consumer's annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the consumer for the physical disability waiver service has not occurred.
- g. The consumer receives services from other Medicaid providers.
- h. The consumer or legal representative requests termination from the services.

441—83.109(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

83.109(1) Appeal to county. Rescinded IAB 2/7/01, effective 2/1/01.

83.109(2) Reconsideration request to IME medical services unit. Rescinded IAB 9/5/12, effective 11/1/12.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.110(249A) County reimbursement. Rescinded IAB 10/6/99, effective 10/1/99.

441—83.111(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.112 to 83.120 Reserved.

DIVISION VII—HCBS CHILDREN'S MENTAL HEALTH WAIVER SERVICES

441—83.121(249A) Definitions.

“*Assessment*” means the review of the consumer's current functioning in regard to the consumer's situation, needs, abilities, desires, and goals.

“*Care coordinator*” means the professional who assists members in care coordination as described in 441—paragraph 78.53(1)“b.”

“*Case manager*” means the person designated to provide Medicaid targeted case management services for the consumer.

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

“*Consumer*” means an individual up to the age of 18 who is included in a Medicaid coverage group listed in 441—75.1(249A) and is a recipient of children's mental health waiver services.

“*Deeming*” means considering parental or spousal income or resources as income or resources of a consumer in determining eligibility for a consumer according to Supplemental Security Income program guidelines.

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

“*Guardian*” means a parent of a consumer or a legal guardian appointed by the court.

“*HCBS*” means home- and community-based services provided under a Medicaid waiver.

“*IME*” means the Iowa Medicaid enterprise.

“*IME medical services unit*” means the contracted entity in the Iowa Medicaid enterprise that determines level of care for consumers initially applying for or continuing to receive children’s mental health waiver services.

“*Integrated health home*” means the provision of services to enrolled members as described in 441—subrule 78.53(1).

“*Interdisciplinary team*” means the consumer, the consumer’s family, and persons of varied professional and nonprofessional backgrounds with knowledge of the consumer’s needs, as designated by the consumer and the consumer’s family, who meet to develop a service plan based on the individualized needs of the consumer.

“*ISIS*” means the department’s individualized services information system.

“*Local office*” means a department of human services office as described in 441—subrule 1.4(2).

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

“*Medical institution*” means a nursing facility, an intermediate care facility for persons with an intellectual disability, a psychiatric hospital or psychiatric medical institution for children, or a state mental health institute that has been approved as a Medicaid vendor.

“*Mental health professional*” means a person who meets all of the following conditions:

1. Holds at least a master’s degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and
2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and
3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

“*Psychiatric medical institution for children level of care*” means that the member has been diagnosed with a serious emotional disturbance and an independent team as identified in 441—subrule 85.22(3) has certified that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient’s psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient’s condition or prevent further regression so that the services will no longer be needed.

“*Serious emotional disturbance*” means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association; and (2) has resulted in a functional impairment that substantially interferes with or limits a consumer’s role or functioning in family, school, or community activities. “Serious emotional disturbance” shall not include neurodevelopmental disorders, substance-related disorders, or conditions or problems classified in the current version of the DSM as “other conditions that may be a focus of clinical attention,” unless these conditions co-occur with another diagnosable serious emotional disturbance.

“*Service plan*” means a person-centered, outcome-based plan of services that is written by the member’s case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“*Skill development*” means that the service provided is habilitative and is intended to impart an ability or capacity to the consumer. Supervision without habilitation is not skill development.

“*Targeted case management*” means Medicaid case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90 for consumers eligible for the children’s mental health waiver.

“*Waiver year*” for the children’s mental health waiver means a 12-month period commencing on July 1 of each year.

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441—83.122(249A) Eligibility. To be eligible for children’s mental health waiver services, a consumer must meet all of the following requirements:

83.122(1) Age. The consumer must be under 18 years of age.

83.122(2) Diagnosis. The consumer must be diagnosed with a serious emotional disturbance.

a. Initial certification. For initial application to the HCBS children’s mental health waiver program, psychological documentation that substantiates a mental health diagnosis of serious emotional disturbance as determined by a mental health professional must be current within the 12-month period before the application date.

b. Ongoing certification. A mental health professional must complete an annual evaluation that substantiates a mental health diagnosis of serious emotional disturbance.

83.122(3) Level of care. The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit or a managed care organization shall certify the applicant’s level of care annually based on information submitted on Form 470-4694, Case Management Comprehensive Assessment, for children aged 3 and under or on the interRAI - Child and Youth Mental Health (ChYMH) for those aged 4 to 20 and other supporting documentation as relevant. For those aged 12 to 18, the interRAI - Adolescent Supplement shall also be completed in addition to the interRAI - Child and Youth Mental Health (ChYMH). Form 470-4694, the interRAI - Child and Youth Mental Health (ChYMH), and the interRAI - Adolescent Supplement are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual’s case manager, integrated health home care coordinator or managed care organization.

83.122(4) Financial eligibility. The consumer must be eligible for Medicaid as follows:

a. Be eligible for Medicaid under an SSI, SSI-related, FMAP, or FMAP-related coverage group; or

b. Be eligible under the special income level (300 percent) coverage group; or

c. Become eligible through application of the institutional deeming rules; or

d. Would be eligible for Medicaid if in a medical institution. For this purpose, deeming of parental or spousal income or resources ceases in the month after the month of application.

83.122(5) Choice of program. The applicant must choose HCBS children’s mental health waiver services over institutional care, as indicated by the signature of the applicant’s parent or legal guardian on the assessment.

83.122(6) Need for service. The consumer must have service needs that can be met under the children’s mental health waiver program, as documented in the service plan developed in accordance with rule 441—83.12(249A).

a. The consumer must be a recipient of case management or integrated health home services or be identified to receive case management or integrated health home services immediately following program enrollment.

b. The total cost of children’s mental health waiver services needed to meet the member’s needs, excluding the cost of environmental modifications, adaptive devices and therapeutic resources, may not exceed \$2,006.34 per month.

c. At a minimum, each consumer must receive one billable unit of a children’s mental health waiver service per calendar quarter.

d. A consumer may not receive children’s mental health waiver services and foster family care services under 441—Chapter 202 at the same time.

e. A consumer may be enrolled in only one HCBS waiver program at a time.
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441—83.123(249A) Application. The Medicaid application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed for an application for HCBS children’s mental health waiver services.

83.123(1) Program limit. The number of persons who may be approved for the HCBS children’s mental health waiver shall be subject to the number of consumers to be served as set forth in the federally approved HCBS children’s mental health waiver. When the number of applicants exceeds the number of consumers specified in the approved waiver, the consumer’s application shall be rejected and the consumer’s name shall be placed on a waiting list.

a. The local office shall determine if a payment slot is available by the end of the fifth working day after receipt of:

(1) A completed Form 470-2297, Health Services Application, from a consumer who is not currently a Medicaid member; or

(2) A written request signed and dated by a Medicaid member’s parent or legal guardian.

b. When a payment slot is available, the local office shall enter the application into ISIS to begin the waiver approval process.

(1) The department shall hold the payment slot for the consumer as long as reasonable efforts are being made to arrange services and the consumer has not been determined to be ineligible for the program.

(2) If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer must reapply for a new slot.

c. If no payment slot is available, the department shall enter the names of persons on a waiting list according to the following:

(1) The names of applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department;

(2) The names of Medicaid members shall be added to the waiting list on the date as specified in paragraph 83.123(1) “a.”

(3) In the event that more than one application is received at one time, the names of consumers shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

d. Consumers whose names are on the waiting list shall be contacted to reapply as slots become available, based on the order of the waiting list, so that the number of approved consumers on the program is maintained.

(1) Once a payment slot is assigned, the department shall give written notice to the consumer within five working days.

(2) The department shall hold the payment slot for 30 days for the consumer to file a new application.

(3) If an application has not been filed within 30 days, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer originally assigned the slot must reapply for a new slot.

83.123(2) Approval of waiver eligibility.

a. Time limit. Applications for the HCBS children’s mental health waiver program shall be processed within 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal Supplemental Security Income (SSI) benefits.

(2) The application is pending because the department has not received information for a reason that is beyond the control of the consumer or the department.

(3) The application is pending because the assessment has not been completed. When a determination is not completed 90 days after the date of application due to the lack of a completed assessment, the application shall be denied.

b. Notice of decisions. The department shall mail or give decisions to the applicant on the dates when eligibility and level of care determinations are completed.

83.123(3) Effective date of eligibility. The effective date of a consumer's eligibility for children's mental health waiver services shall be the first date that all of the following conditions exist:

a. All eligibility requirements are met; and

b. Eligibility and level of care determinations have been made.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.124(249A) Financial participation. A consumer must contribute to the cost of children's mental health waiver services to the extent of the consumer's total income less 300 percent of the maximum monthly payment for one person under the federal Supplemental Security Income (SSI) program.

441—83.125(249A) Redetermination. The department shall redetermine a consumer's eligibility for the children's mental health waiver at least once every 12 months or when there is significant change in the consumer's situation or condition.

83.125(1) Eligibility review.

a. Every 12 months, the department shall review a consumer's eligibility in accordance with procedures in rule 441—76.7(249A). The review shall verify continuing eligibility factors as specified in rule 441—83.122(249A).

b. The IME medical services unit or a managed care organization shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to rule 441—83.122(249A) and the appeal process at rule 441—83.129(249A), based on the completed information submission tool designated in 83.122(3) and other supporting documentation as relevant.

c. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

d. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.125(2) Continuation of eligibility. A consumer's waiver eligibility shall continue until one of the following conditions occurs.

a. The consumer fails to meet eligibility criteria listed in rule 441—83.122(249A).

b. The consumer is an inpatient of a medical institution for 120 or more consecutive days.

(1) After the consumer has spent 120 consecutive days in a medical institution, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

(2) If the consumer returns home after 120 consecutive days, the consumer must reapply for children's mental health waiver services, and the IME medical services unit must redetermine the consumer's level of care.

c. The consumer does not reside at the consumer's natural home for a period of 60 consecutive days. After the consumer has resided outside the home for 60 consecutive days, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

83.125(3) Payment slot. When a consumer loses waiver eligibility, the consumer's assigned payment slot shall revert for use to the next consumer on the waiting list.

[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.126(249A) Allowable services. Services allowable under the children’s mental health waiver shall be provided as set forth in rule 441—78.52(249A) and shall include:

1. Environmental modifications, adaptive devices and therapeutic resources;
2. Family and community support services;
3. In-home family therapy; and
4. Respite care.

441—83.127(249A) Service plan. The consumer’s case manager or integrated health home care coordinator shall prepare an individualized service plan for each consumer that meets the requirements set for case plans in rule 441—130.7(234).

83.127(1) The service plan shall be developed through an interdisciplinary team process.

83.127(2) The service plan shall be developed annually or when there is significant change in the consumer’s situation or condition.

83.127(3) The service plan shall be based on information in the completed information submission tool designated in subrule 83.122(3) and other supporting documentation as relevant.

83.127(4) The service plan shall specify the type and frequency of the waiver services and the providers that will deliver the services.

83.127(5) The service plan shall identify and justify any restriction of the consumer’s rights.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.128(249A) Adverse service actions.

83.128(1) Denial. An application for children’s mental health waiver services shall be denied when the department determines that:

- a. The consumer is not eligible for or in need of waiver services.
- b. Needed services are not available or received from qualified providers.
- c. Service needs exceed the limit on aggregate monthly costs established in 83.122(6) “c” or are not met by the services provided.

83.128(2) Termination. A consumer’s participation in the children’s mental health waiver program may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) “a,” “b,” “c,” “g,” or “h” apply.
- b. The costs of the children’s mental health waiver services for the consumer exceed the aggregate monthly costs established in 83.122(6) “c.”
- c. The consumer receives care in a hospital, nursing facility, psychiatric hospital serving children under the age of 21, or psychiatric medical institution for children for 120 days in any one stay.
- d. The physical or mental condition of the consumer requires more care than can be provided in the consumer’s own home, as determined by the consumer’s case manager or integrated health home care coordinator.
- e. Service providers are not available.

83.128(3) Reduction. Reduction of services shall apply as specified in 441—paragraphs 130.5(3) “a” and “b.”

[ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.129(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

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CHAPTER 110
CHILD DEVELOPMENT HOMES

PREAMBLE

This chapter establishes registration procedures for child development homes. Included are application and renewal procedures, standards for providers, and procedures for compliance checks and complaint investigations.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

441—110.1(237A) Definitions.

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

“*Assistant*” means a responsible person 14 years of age or older. The assistant may never be left alone with children. Ultimate responsibility for supervision is with the child care provider.

“*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 child’s parent, guardian, or custodian for periods of less than 24 hours per day per child on a regular basis. “*Child care*” shall not mean special activity programs that meet on a regular basis such as music or dance classes, organized athletics or sports programs, scouting programs, or hobby or craft classes or clubs.

“*Child care facility*” or “*facility*” means a child care center, a preschool, or a registered child development home.

“*Child care home*” means a person or program providing child care to five or fewer children at any one time that is not registered to provide child care under this chapter, as authorized under Iowa Code section 237A.3.

“*Child development home*” means a person or program registered under this chapter that may provide child care to six or more children at any one time.

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

“*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.

“*Parent*” means parent or legal guardian.

“*Part-time hours*” means the hours that child development homes in categories B and C are allowed to exceed their maximum preschool- or school-age capacity. A provider may use a total of up to 180 hours per month as part-time hours. No more than two children using part-time hours may be in the child development home at any one time.

“*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 registration or is registered.
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.
5. The person will reside or resides in a child care home that is not registered but that receives public funding for providing child care.

“*Provider*” means the person or program that applies for registration to provide child care and is approved as a child development home.

“*Registration*” means the process by which child care providers certify that they comply with rules adopted by the department.

“*Registration certificate*” means the written document issued by the department to publicly state that the provider has certified in writing compliance with the minimum requirements for registration of a child development home.

“*School*” means kindergarten or a higher grade level.

“*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.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

441—110.2(237A) Application for registration. A provider shall apply for registration on Form 470-3384, Application for Child Development Home Registration, provided by the department’s local office or, if available, on the department’s website. The provider shall also use Form 470-3384 to inform the department of any changes in circumstances that would affect the registration.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

441—110.3(237A) Renewal of registration. Renewal of registration shall be completed every 24 months. To request renewal, a provider shall submit Form 470-3384, Application for Child Development Home Registration, and copies of certificates of training, which shall be retained in the registration file. The registration renewal process shall include completion of child abuse, sex offender, and criminal record checks.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

441—110.4(237A) Compliance checks. Prior to registration, a compliance visit to inspect for compliance with health, safety, and fire standards shall be completed.

An unannounced compliance visit shall be conducted not less than annually to check for compliance with health, safety, and fire standards as well as all child care regulatory standards. Completed evaluation checklists shall be placed in the registration files.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

441—110.5(237A) Parental access. Parents shall be afforded unlimited access to their children and to the people caring for their children during the normal hours of operation or whenever their children are in the care of the child development home, unless parental contact is prohibited by court order.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

441—110.6(237A) Number of children. The number of children in a child development home shall conform to the following standards:

110.6(1) Limit. Except as provided in subrule 110.6(3), no greater number of children shall be received for care at any one time than the number authorized on the registration certificate.

110.6(2) Children counted. To determine the number of children cared for at any one time in a child development home, each child present in the child development home shall be considered to be receiving care unless the child is described by one of the following exceptions:

a. The child’s parent, guardian, or custodian established or operates the child development home and either the child is attending school or the child receives child care full-time on a regular basis from another person.

b. The child has been present in the child development home for more than 72 consecutive hours and meets the requirements of the exception in paragraph 110.6(2)“*a*” as though the person who established or operates the child development home is the child’s parent, guardian, or custodian.

110.6(3) Exception for emergency school closing. On days when schools start late, are dismissed early, or are canceled or closed due to emergencies such as inclement weather, physical plant failure,

structural damage, or public health emergency, a child development home may have additional children present in accordance with the authorization for the registration category of the home and subject to all of the following conditions:

- a. The child development home has prior written approval from the parent or guardian of each child present in the home concerning the presence of additional children in the home.
- b. One or more of the following conditions are applicable to each of the additional children present in the child development home:
 - (1) The home provides care to the child on a regular basis for periods of less than two hours.
 - (2) If the child were not present in the child development home, the child would be unattended.
 - (3) The home regularly provides care to a sibling of the child.
- c. The provider shall maintain a written record including the date of the emergency school closing, the reason for the closing, and the number of children in care on that date.

[ARC 2647C, IAB 8/3/16, effective 10/1/16; ARC 5488C, IAB 3/10/21, effective 5/1/21]

441—110.7(237A) Provider requirements.

110.7(1) Provider. The provider shall:

- a. Give careful supervision at all times.
- b. Exchange information with the parent of each child frequently to enhance the quality of care.
- c. Give consistent, dependable care and be capable of handling emergencies.
- d. Be present at all times except when emergencies occur or an absence is planned, at which time care shall be provided by a department-approved substitute. When an absence is planned, the provider shall give parents at least 24 hours' prior notice.
- e. 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 the provider's ability to give careful supervision.

110.7(2) Substitutes. The provider shall assume responsibility for providing adequate and appropriate supervision at all times when children are in attendance. Any designated substitute shall have the same responsibility for providing adequate and appropriate supervision. Ultimate responsibility for supervision shall be with the provider.

- a. All standards in this chapter regarding supervision and care of children shall apply to substitutes.
- b. Except in emergency situations, the provider shall inform parents in advance of the planned use of a substitute.
- c. The substitute must be 18 years of age or older.
- d. Use of a substitute shall be limited to:
 - (1) No more than 25 hours per month.
 - (2) An additional period of up to two weeks in a 12-month period.
- e. The provider shall maintain a written record of the number of hours care is provided by a substitute, including the date of the care and the name of the substitute.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

441—110.8(237A) Standards. Conditions in the home shall be safe, sanitary, and free of hazards. The provider shall certify that the child development home meets the following standards and also the standards in either rule 441—110.13(237A), 441—110.14(237A), or 441—110.15(237A), specific to the category of home for which the provider requests registration.

110.8(1) Facility requirements.

- a. The home shall have a nonpay, working landline or mobile telephone with emergency numbers posted for police, fire, ambulance, and the poison information center. The number for each child's parent, for a responsible person who can be reached when the parent cannot, and for the child's physician shall be written on paper and readily accessible by the telephone. The home must prominently display all emergency information, and all travel vehicles must have a paper copy of emergency parent contact information.
- b. Electrical wiring shall be maintained, and all accessible electrical outlets shall be tamper-resistant outlets or shall be safely capped. Electrical cords shall be properly used. Improper use

includes the running of cords under rugs, over hooks, or through door openings or other use that has been known to be hazardous.

c. Combustible materials shall be kept a minimum of three feet away from furnaces, stoves, water heaters, and gas dryers.

d. Approved safety gates at stairways and doors shall be provided and used as needed.

e. Annual laboratory analysis of a private water supply shall be conducted to show satisfactory bacteriological quality. When children under the age of two are to be cared for, the analysis shall include a nitrate analysis. When private water supplies are determined unsuitable for drinking, commercially bottled water or water treated through a process approved by the health department or designee shall be provided.

f. A safety barrier shall surround any heating stove or heating element, in order to prevent burns.

g. The home shall have at least one 2A 10BC-rated fire extinguisher located in a visible and readily accessible place on each child-occupied floor.

h. The home shall have at least one single-station, battery-operated, UL-approved smoke detector in each child-occupied room and at the top of every stairway. Each smoke detector shall be installed according to the manufacturer's recommendations. The provider shall test each smoke detector monthly and keep a record of testing for inspection purposes.

i. Smoking and the use of tobacco products shall be prohibited at all times in the home and in every vehicle in which children receiving care in the home are transported. Smoking and the use of tobacco products shall be prohibited in the outdoor play area during the home's hours of operation. "No smoking" signs shall be posted at every entrance of the child care home and in every vehicle used to transport children. All signs shall include:

(1) The telephone number for reporting complaints, and

(2) The Internet address of the department of public health (www.iowasmokefreeair.gov).

j. Homes served by private sewer systems shall be in compliance with discharge restrictions identified at 567—Chapter 69. Discharge of untreated waste water from private sewage disposal systems is prohibited. Compliance shall be verified by the local board of health at the time of registration renewal and new registration.

k. A provider operating in a facility built before 1960 shall assess and control lead hazards before being issued an initial child development home registration or a renewal of the registration. To comply with this requirement, the provider shall:

(1) Conduct a visual assessment of the facility for lead hazards that exist in the form of chipping or peeling paint;

(2) Apply interim controls on any chipping or peeling paint found, using lead-safe work methods in accordance with and as defined by department of public health rules at 641—Chapters 69 and 70, unless a certified inspector as defined in 641—Chapter 70 determines that the paint is not lead-based paint; and

(3) Submit Form 470-4755, Lead Assessment and Control, as verification of the visual assessment and completion of interim controls, if necessary.

l. The child development home shall be located in a single-family residence that is owned, rented, or leased by the person, or, for dual registrations, at least one of the persons, who is named on the child development home's certificate of registration.

m. Any driver who transports children for any purpose shall have a valid driver's license and adequate motor vehicle insurance that authorizes the driver to operate the type of vehicle being driven. Child restraint devices shall be utilized in compliance with Iowa Code section 321.446.

n. Providers shall inform parents of the presence of any pet in the home.

(1) Each dog or cat in the household shall undergo an annual health examination by a licensed veterinarian. Acceptable veterinary examinations shall be documented on Form 470-5153, Veterinary Health Certificate. This examination shall verify that the animal's routine immunizations, particularly rabies, are current and that the animal shows no evidence of endoparasites (roundworms, hookworms, whipworms) and ectoparasites (fleas, mites, ticks, lice).

(2) Each pet bird in the household shall be purchased from a dealer licensed by the Iowa department of agriculture and land stewardship and shall be examined by a veterinarian to verify that the bird is free

of infectious diseases. Acceptable veterinary examinations shall be documented on Form 470-5153, Veterinary Health Certificate. Children shall not handle pet birds.

(3) Aquariums shall be well maintained and installed in a manner that prevents children from accessing the water or pulling over a tank.

(4) All animal waste shall be immediately removed from the children's areas and properly disposed of. Children shall not perform any feeding or care of pets or cleanup of pet waste.

(5) No animals shall be allowed in the food preparation, food storage, or serving areas during food preparation and serving times.

o. Using an injury report form, the provider shall document all injuries that require first aid or medical care. The form shall be completed on the date of occurrence, shared with the parent, and maintained in the child's file.

p. The provider shall have written policies regarding the care of mildly ill children and the exclusion of children due to illness and shall inform parents of these policies.

q. The provider shall have written policy and procedures for responding to health-related emergencies.

r. The certificate of registration shall be displayed in a conspicuous place.

s. Serious injuries.

(1) Serious injuries, as defined in Iowa Code section 702.18, that occur in a child care facility or when a child is in the care of child care facility staff shall be reported to the department within 24 hours of the incident.

(2) Serious injuries shall be documented and information maintained in the child's file as required by subrule 110.9(4).

110.8(2) Use of outdoor space.

a. A safe outdoor play area shall be maintained in good condition throughout the year. The play area shall be fenced off when located on a busy thoroughfare or near a hazard which may be injurious to a child and shall have both sunshine and shade areas. The play area shall be kept free from litter, rubbish, and flammable materials and shall be free from contamination by the drainage or ponding of sewage, household waste, or storm water.

b. When there is a swimming or wading pool on the premises:

(1) The wading pool shall be drained daily and shall be inaccessible to children when it is not in use.

(2) An aboveground or in-ground swimming pool that is not fenced shall be covered whenever the pool is not in use. The cover shall meet or exceed the ASTM International (formerly known as the American Society for Testing and Materials) specification intended to reduce the risk of drowning by inhibiting access to the water by children under five years of age.

(3) An uncovered aboveground swimming pool shall be enclosed with an approved fence that is nonclimbable and is at least four feet high.

(4) An uncovered in-ground swimming pool shall be enclosed with an approved fence that is nonclimbable and is at least four feet high and flush with the ground.

c. If children are allowed to use an aboveground or in-ground swimming pool:

(1) Written permission from parents shall be available for review.

(2) Equipment needed to rescue a child or adult shall be readily accessible.

(3) The child care provider shall accompany the children and provide constant supervision while the children use the pool.

(4) The child care provider shall complete training in cardiopulmonary resuscitation for infants, toddlers, and children, according to the criteria of the American Red Cross or the American Heart Association.

110.8(3) Medications and hazardous materials.

a. All medicines and poisonous, toxic, or otherwise unsafe materials shall be secured from access by a child.

b. A first-aid kit shall be available and easily accessible whenever children are in the child development home, in the outdoor play area, in vehicles used to transport children, 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. The kit shall, at a minimum, include adhesive bandages, bottled water, disposable tweezers, and disposable plastic gloves.

c. Medications shall be given only with the parent's or doctor's written authorization. Each prescribed medication shall be accompanied by a physician's or pharmacist's direction. Both nonprescription and prescription medications shall be in the original container with directions intact and labeled with the child's name. All medications shall be stored properly and, when refrigeration is required, shall be stored in a separate, covered container so as to prevent contamination of food or other medications. All medications shall be stored so they are inaccessible to children. Any medication administered to a child shall be recorded, and the record shall indicate the name of the medication, the date and time of administration, and the amount administered.

d. All new providers and providers renewing registrations after September 30, 2016, shall not provide medications to a child if the provider has not completed preservice/orientation training that includes medication administration.

e. The provider shall establish procedures related to infectious disease control and handling of any bodily excrement or discharge, including blood and breast milk. Soiled diapers shall be stored in containers separate from other waste.

110.8(4) Emergency plans. Emergency plans in case of man-made or natural disaster shall be written and posted by the primary and secondary exits. The plans shall clearly map building evacuation routes and tornado and flood shelter areas.

a. Fire and tornado drills shall be practiced monthly, and the provider shall keep documentation evidencing compliance with monthly practice on file for the current year and the previous year.

b. The provider must have procedures in place for the following:

- (1) Evacuation to safely leave the facility.
- (2) Relocation to a common, safe location after evacuation.
- (3) Shelter-in-place to take immediate shelter where the child is when it is unsafe to leave that location due to the emergent issue.
- (4) Lockdown to protect children and providers from an external situation.
- (5) Communication and plans for reunification with families.
- (6) Continuity of operations.
- (7) To address the needs of individual children, including those with functional or access needs.

110.8(5) Safe sleep.

a. The provider shall follow safe sleep practices as recommended by the American Academy of Pediatrics for infants under the age of one. Infant sleep shall conform to the following standards:

- (1) Infants shall always be placed on their backs for sleep.
- (2) Infants shall be placed on a firm mattress with a tight fitted sheet that meets U.S. Consumer Product Safety Commission federal standards.
- (3) Infants shall not be allowed to sleep on a bed, sofa, air mattress or other soft surface.
- (4) No toys, soft objects, stuffed animals, pillows, bumper pads, blankets, or loose bedding shall be allowed in the sleeping area with the infant.
- (5) No co-sleeping shall be allowed.
- (6) Sleeping infants shall be actively observed by sight and sound.
- (7) If an alternate sleeping position is needed, a signed physician or physician assistant authorization with statement of medical reason is required.

b. No child shall be allowed to sleep in any item not designed for sleeping including, but not limited to, an infant seat, car seat, swing, or bouncy seat.

c. 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 ASTM International 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 home shall maintain 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.

d. All items used for sleeping must be used in compliance with manufacturer standards for age and weight of the child.

110.8(6) Discipline. Discipline shall conform to the following standards:

a. Corporal punishment, including spanking, shaking and slapping, shall not be used.

b. Punishment that is humiliating or frightening or that causes pain or discomfort to the child shall not be used.

c. Punishment shall not be administered because of a child's illness, or progress or lack of progress in toilet training, nor shall punishment or threat of punishment be associated 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.

e. Discipline shall be designed to help the child develop self-control, self-esteem, and respect for the rights of others.

110.8(7) Meals and snacks.

a. Regular meals and midmorning or midafternoon snacks shall be provided. The meals and snacks shall be well-balanced, nourishing, and in appropriate amounts as defined by the USDA Child and Adult Care Food Program.

b. Children may bring food to the child development home for their own consumption but shall not be required to provide their own food.

c. Clean, sanitary drinking water shall be readily available to children in indoor and outdoor areas, throughout the day.

110.8(8) Activity program. There shall be an activity program which promotes self-esteem and exploration and includes:

a. Active play.

b. Quiet play.

c. Activities for large-muscle development.

d. Activities for small-muscle development.

e. Play equipment and materials in a safe condition, for both indoor and outdoor activities which are developmentally appropriate for the ages and number of children present.

[ARC 2647C, IAB 8/3/16, effective 10/1/16; ARC 3096C, IAB 6/7/17, effective 8/1/17; ARC 3556C, IAB 1/3/18, effective 3/1/18; ARC 5488C, IAB 3/10/21, effective 5/1/21]

441—110.9(237A) Files.

110.9(1) A provider file shall be maintained and shall contain the following:

a. A physical examination report. Providers and all members of a provider's household over the age of 12 shall have good health as evidenced by a preregistration physical examination. Acceptable physical examinations shall be documented on Form 470-5152, Child Care Provider Physical Examination Report. The physical examination shall include any necessary testing for communicable diseases; shall include a discussion regarding current Advisory Committee on Immunization Practices (ACIP)-recommended vaccinations; shall be performed by a licensed medical doctor, doctor of osteopathy, physician assistant or advanced registered nurse practitioner within six months prior to the provider's registration; and shall be repeated at least every three years. All children residing in the household who are 12 years of age or younger must have the medical documentation outlined in paragraphs 110.9(4) "*d*," "*f*," and "*g*."

b. Certificates or other documentation from the department verifying the following:

(1) Required training as set forth in subrule 110.10(1).

(2) Completion of all record checks as required in subrule 110.11(3), at initial application, at each application for change, and at each application for renewal.

110.9(2) An individual file for each staff assistant shall be maintained and shall contain the following:

a. Documentation from the department which confirms that the record checks required under subrule 110.11(3) have been completed and authorizes or conditionally limits the person's involvement with child care.

b. A completed Form 470-5152, Child Care Provider Physical Examination Report, that meets the requirements of paragraph 110.9(1) "a."

c. Certification of a minimum of two hours of approved training relating to the identification and reporting of child abuse as required by Iowa Code section 232.69, completed within three months of employment.

110.9(3) An individual file for each substitute shall be maintained and shall contain the following:

a. Documentation from the department which confirms that the record checks required under subrule 110.11(3) have been completed and authorizes or conditionally limits the person's involvement with child care.

b. A completed Form 470-5152, Child Care Provider Physical Examination Report, that meets the requirements of paragraph 110.9(1) "a."

c. Certification of a minimum of two hours of approved training relating to the identification and reporting of child abuse as required by Iowa Code section 232.69, completed within three months of employment.

d. Certification in first aid that meets the requirements of paragraph 110.10(1) "c."

e. Certification or other documentation that minimum health and safety training has been completed in compliance with paragraph 110.10(1) "a" within three months of a substitute's hiring or before a substitute provides care, whichever occurs first.

110.9(4) Children's files. An individual file for each child shall be maintained and updated annually or when the provider becomes aware of changes. The file shall contain:

a. Identifying information including, at a minimum, the child's name and birth date; the parent's name, address and telephone number; special needs of the child; and the parent's work address and telephone number.

b. Emergency contact information including, at a minimum, where the parent can be reached, the name, street address, city and telephone number of the child's regular source of health care, and the name, telephone number, and relationship to the child of another adult available in case of emergency.

c. A signed medical consent from the parent authorizing emergency medical and dental treatment.

d. An admission physical examination report signed by a licensed physician or a designee in a clinic supervised by a licensed physician.

(1) The date of the physical examination shall not be more than 12 months before the child's first day of attendance at the child development home.

(2) The written report shall include the child's past health history, status of the child's present health, allergies and restrictive conditions, and recommendations for continued care when necessary.

(3) For a child who is five years of age or older and enrolled in school, a statement of health status signed by the parent or legal guardian may be substituted for the physical examination report.

(4) The examination report or statement of health status shall be on file before the child's first day of care.

e. A statement of health condition signed by a physician or designee and submitted annually from the date of the admission physical examination. For a child who is five years of age or older and enrolled in school, a statement of health status signed by the parent or legal guardian may be substituted for the physician statement.

f. For each school-age child, on the first day of attendance, documentation of a physical examination that was completed at the time of school enrollment or since.

g. A signed and dated immunization certificate provided by the Iowa department of public health. For the school-age child, a copy of the most recent immunization record shall be acceptable.

h. For any child with allergies, a written emergency plan in case of an allergic reaction. A copy of this information shall accompany the child if the child leaves the premises.

i. A list that is signed by the parent and names persons authorized to pick up the child. The authorization shall include the name, telephone number, and relationship of the authorized person to the child.

j. Written permission from the parent for the child to attend activities away from the child development home. The permission shall include:

- (1) Times of departure and arrival.
- (2) Destination.
- (3) Names of persons who will be responsible for the child.

k. Injury report forms documenting injuries requiring first aid or medical care.

l. If the child meets the definition of homelessness as defined by Section 725(2) of the McKinney-Vento Homeless Education Assistance Act, the family shall receive a 60-day grace period to obtain medical documentation.

[ARC 2647C, IAB 8/3/16, effective 10/1/16; ARC 3095C, IAB 6/7/17, effective 8/1/17; ARC 4753C, IAB 11/6/19, effective 12/11/19]

441—110.10(237A) Professional development.

110.10(1) Required training.

a. Prior to registration, the provider shall complete minimum health and safety trainings, approved by the department, in all of the following areas:

- (1) Prevention and control of infectious disease, including immunizations.
- (2) Prevention of sudden infant death syndrome and use of safe sleep practices.
- (3) Administration of medication, consistent with standards for parental consent.
- (4) Prevention of and response to emergencies due to food and allergic reactions.
- (5) Building and physical-premises safety, including identification of and protection from hazards that can cause bodily injury, such as electrical hazards, bodies of water, and vehicular traffic.
- (6) Prevention of shaken baby syndrome and abusive head trauma.
- (7) Emergency preparedness and response planning for emergencies resulting from a natural disaster or a human-caused event.
- (8) Handling and storage of hazardous materials and the appropriate disposal of biocontaminants.
- (9) Precautions in transporting children.
- (10) Child development, on or after August 1, 2017.

b. Prior to registration, the provider shall complete two hours of Iowa's training for mandatory reporting of child abuse as required by Iowa Code section 232.69. The provider shall maintain a valid certificate indicating expiration date.

c. Prior to registration, the provider shall complete first-aid and cardiopulmonary resuscitation (CPR) training that meets the following requirements:

- (1) Training shall be provided by a nationally recognized training organization, such as the American Red Cross, American Heart Association, National Safety Council, the American Safety and Health Institute, or MEDIC First Aid or by an equivalent trainer using curriculum approved by the department.
- (2) CPR training shall include certification in infant and child CPR.
- (3) The provider shall maintain a valid certificate indicating the date of first-aid training and the expiration date.
- (4) The provider shall maintain a valid certificate indicating the date of CPR training and the expiration date.

d. During each two-year registration period, the provider shall receive a minimum of 24 hours of training from one or more of the following content areas. A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

- (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.

e. Minimum health and safety training may be required if content has significant changes which warrant that the training be renewed.

f. A provider who has completed training through a child care resource and referral agency or community college within six months prior to initial registration shall be permitted to count the training toward the provider's total training required during the initial registration.

110.10(2) Approved training.

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 by 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, American Heart Association, National Safety Council, American Safety and Health Institute 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 (CACFP) 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.

(14) Organizations that are certified by the International Association for Continuing Education and Training (IACET).

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 110.10(2) "a" or an entity approved under paragraph 110.10(2) "h."

c. Approved training shall be made available to Iowa child care providers through the child care provider training registry.

d. Training received in a group setting may include distance learning opportunities, such as training conducted over the Iowa communications network, online courses, or web conferencing (webinars) if:

(1) The training meets the requirements in subrule 110.10(3);

(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.

e. The department will not approve more than eight hours of training delivered in a single day.

- f.* The department may randomly monitor any state-approved training for quality control purposes.
- g.* Training conducted with the provider either during the hours of operation of the facility, provider lunch hours, or while children are resting must not diminish the required ratio coverage. The provider shall not be actively engaged in care and supervision and simultaneously participate in training.
- h.* A training organization not approved by the department may submit a request for review 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.

110.10(3) Elements of 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 teacher-student interaction and timely feedback, including questions and answers and with evaluation of learning.
- d.* For each participant, a certificate of training 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.

[ARC 2647C, IAB 8/3/16, effective 10/1/16; ARC 3095C, IAB 6/7/17, effective 8/1/17; ARC 3556C, IAB 1/3/18, effective 3/1/18; ARC 4753C, IAB 11/6/19, effective 12/11/19]

441—110.11(234) Registration decision. The department shall issue Form 470-3498, Certificate of Registration, when an applicant meets all requirements for registration. Each local office of the department shall maintain a current list of registered child development homes as a referral service to the community.

110.11(1) Registration shall be denied or revoked if the department finds a hazard to the safety and well-being of a child and the provider cannot correct or refuses to correct the hazard, even though the hazard may not have been specifically listed under the health and safety rules. Registration may also be denied or revoked if the department determines that the provider has failed to comply with standards imposed by law and these rules.

110.11(2) Record of all denials or revocations of registration and the documentation of reasons for denying or revoking the registration shall be kept in an open file.

110.11(3) Record checks.

a. Applicability. The department shall conduct Iowa criminal history record and child abuse record checks for each registrant, substitute or staff member, anyone living in the home who is 14 years of age or older, and anyone having access to a child when the child is alone. The department shall conduct national criminal history record checks, based on fingerprints, for each registrant, substitute or staff member, anyone living in the home who is 18 years of age or older, and anyone 18 years of age or older having access to a child when the child is alone. In accordance with Iowa Code section 726.23, minors under the age of 18 will not be subject to the fingerprint requirement.

(1) The purpose of these record checks is to determine whether the person has committed a transgression that prohibits or limits the person's involvement with child care.

(2) The department may also conduct criminal history record and child abuse record checks in other states and may conduct dependent adult abuse, sex offender registry, and other public or civil offense record checks in Iowa or other states.

(3) Effective July 1, 2013, registration or renewal certificates shall not be issued until the results of all state and national record checks have been received and, when necessary, evaluated.

b. Authorization. The person subject to record checks shall complete the Iowa department of human services record check authorization form; Form DCI-45, Waiver Agreement; Form FD-258, Federal Fingerprint Card; 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 history records shall be completed before the person's involvement with child care. Iowa records checks shall be repeated at a minimum of every two years and when the department or the registrant becomes aware of any possible transgressions. The department is responsible for the cost of conducting the Iowa records checks.

d. National criminal history record checks. Fingerprint-based checks of national criminal history records shall also be completed before a person's involvement with child care. This requirement shall be for an initial application for registration or a renewal application for registration. The national criminal history record check shall be repeated for each person subject to the check every four years and when the department or registrant becomes aware of any new transgressions committed by that person in another state. The department is responsible for the cost of conducting the national criminal history record check.

(1) The registrant is responsible for any costs associated with the taking (rolling) of fingerprints of all persons subject to record checks and for submitting the fingerprints to the department so that the national criminal history record check can be completed. Fingerprints may be taken (rolled) by law enforcement agencies or by agencies or companies that specialize in taking (rolling) fingerprints.

(2) The department shall provide fingerprints to the department of public safety no later than ten business days after receipt of the fingerprint cards. The department shall submit the fingerprints on forms or in a manner allowed by the department of public safety.

(3) The department may rely on the results of previously conducted national criminal history record checks when a person subject to a record check in one child development home or child care home submits a request for involvement with child care in another child development home or child care home, so long as the person's national criminal history record check is within the allowable four-year time frame. All initial or new applications shall require a new national criminal history record check.

e. Mandatory prohibition. A person with any of 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) A requirement to be listed on any state sex offender registry or the national sex offender registry.
- (3) Any of the following felony convictions:
 1. Child endangerment or neglect or abandonment of a dependent person.
 2. Domestic abuse.
 3. Crime against a child including, but not limited to, sexual exploitation of a minor.
 4. Forcible felony.
 5. Arson.

(4) A record of a misdemeanor conviction of a crime against a child that constitutes one of the following offenses:

1. Child abuse.
2. Child endangerment.
3. Sexual assault.
4. Child pornography.

(5) If a person subject to a record check refuses to consent to a record check, the person shall be prohibited from involvement with child care.

(6) If a person has been convicted of a crime and makes what the person knows to be a false statement of material fact in connection with the conviction or record check, the person shall be prohibited from involvement with child care.

f. Mandatory time-limited prohibition.

(1) A person with the following conviction or founded abuse report 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 .
2. Founded abuse that was determined to be physical abuse.

(2) After the five-year prohibition period (from the date of the conviction or the founded abuse report) as defined in subparagraph 110.11(3)“f”(1), the person may request the department to perform an evaluation under paragraph 110.11(3)“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 110.11(3)“f”(2), the department shall evaluate the transgression and make a decision about the person’s involvement with child care.

(1) The person with the transgression shall complete and return the record check evaluation form 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 within ten calendar days of the date on the form shall result in denial or revocation of the registration certificate.

(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.

(4) When a person subject to a record check has a transgression that has been determined in a previous evaluation not to warrant prohibition of the person’s involvement with child care and the person has no subsequent transgressions, an exemption from reevaluation of the latest record check is authorized. The person may commence employment with another child care facility in accordance with the department’s previous evaluation. The exemption is subject to all of the following conditions:

1. The position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.

2. Any restrictions placed on the person’s employment by the department in the previous evaluation shall remain applicable in the person’s subsequent employment.

3. The person subject to the record check has maintained a copy of the previous evaluation and provides the evaluation to the subsequent employer or the previous employer provides to the subsequent employer the previous evaluation from the person’s personnel file pursuant to the person’s authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, the record check shall be reevaluated.

4. The subsequent employer may request a reevaluation of the record check and may employ the person while the reevaluation is being performed.

h. Evaluation decision. 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 or corrective action plan.

(1) Within 30 calendar days of receipt of a completed record check evaluation, the department shall make a decision on the person’s involvement with child care.

(2) Within 30 calendar days of receipt of a completed record check evaluation, the department shall mail to the person subject to an evaluation a record check decision that explains the decision reached regarding the evaluation of the transgression and a notice of decision: child care.

(3) The department shall issue a notice of decision: child care prohibiting involvement with child care when the person subject to an evaluation fails to complete the record check evaluation within the ten-calendar-day time frame.

(4) If the department determines, through the record check evaluation process, 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.

(5) The department may permit a person who is evaluated to maintain involvement with child care if the person complies with the department's conditions relating to the person's involvement with child care, which may include completion of additional training or an individually designed corrective action plan, or both. For an employee of a registrant, these conditional requirements shall be developed with the registrant. All conditions placed on a person's involvement with child care shall be communicated, in writing, to both the person subject to the evaluation and the registrant.

(6) The department shall reevaluate any transgressions where a state or federal law change requires different considerations of the transgression than had been previously applied.

i. Notice to parents of abuse in care. If there has been founded child abuse committed by an owner, director, or staff member of the child care facility or child care home, the department's administrator shall notify the parents, guardians, and legal custodians of each child for whom the facility or child care home provides care.

(1) The child care facility or child care home shall cooperate with the department in providing the names and addresses of the parent, guardian, or custodian of each child for whom the facility provides child care.

(2) This information shall be provided to the department within ten calendar days from the date of the initial request.

(3) Failure or refusal to provide the requested information may result in revocation of registration.

110.11(4) If the department has denied or revoked a registration because the provider has continually or repeatedly failed to operate in compliance with Iowa Code chapter 237A and this chapter, the person shall not own or operate a registered facility for a period of 12 months from the date of denial or revocation. The department shall not act on an application for registration submitted by the applicant or provider during the 12-month period. The applicant shall be prohibited from involvement with child care unless the department specifically permits the involvement.

110.11(5) Required notifications. If a certificate of registration is revoked, the administrator of the department shall notify the parent, guardian, or legal custodian of each child for whom the facility provides care. The provider shall cooperate with the department in providing the name and address of the parent, guardian, or legal custodian of each child for whom the facility provides child care.

110.11(6) Required notifications to the department.

a. The provider shall, within ten days, notify the department of any of the following:

- (1) Changes in assistants or substitutes;
- (2) Changes in household membership;
- (3) Address changes; and
- (4) Criminal convictions.

b. No assistant, substitute, or coprovider shall be utilized in the care of children and no person shall be permitted to reside in the household until approved by the department.

c. If the provider does not notify the department of changes within ten days, the provider may be subject to revocation of registration or to recoupment of child care assistance provided, or both.

110.11(7) Letter of revocation. A letter received by an owner or operator of a child development home initiating action to deny or revoke the home's registration shall be conspicuously posted 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 or revoke an owner's or operator's certificate of registration.

[ARC 2647C, IAB 8/3/16, effective 10/1/16; ARC 4114C, IAB 11/7/18, effective 1/1/19]

441—110.12(237A) Complaints. The department shall conduct an on-site visit when a complaint is received.

110.12(1) After each complaint visit, the department shall document whether the child development home was in compliance with registration requirements.

110.12(2) The written documentation of the department's conclusion as to whether the child development home was in compliance with requirements shall be available to the public. However, the identity of all complainants shall be confidential, unless expressly waived by the complainant.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

441—110.13(237A) Additional requirements for child development home category A. In addition to the requirements in rule 441—110.8(237A), a provider requesting registration in child development home category A shall meet the following standards:

110.13(1) Limits on number of children in care.

a. No more than six children not attending kindergarten or a higher grade level shall be present at any one time.

b. Of these six children, no more than four children who are 24 months of age or younger shall be present at any one time. Of these four children, no more than three may be 18 months of age or younger.

c. In addition to the six children not in school, no more than two children who attend school may be present for a period of less than two hours at a time.

d. No more than eight children shall be present at any one time when an emergency school closing is in effect.

110.13(2) Provider qualifications.

a. The provider shall be at least 18 years old.

b. The provider shall have three written references which attest to character and ability to provide child care.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

441—110.14(237A) Additional requirements for child development home category B. In addition to the requirements in rule 441—110.8(237A), a provider requesting registration in child development home category B shall meet the following standards:

110.14(1) Limits on number of children in care.

a. No more than six children not attending kindergarten or a higher grade level shall be present at any one time.

b. Of these six children, no more than four children who are 24 months of age or younger shall be present at any one time. Of these four children, no more than three may be 18 months of age or younger.

c. In addition to the six children not in school, no more than four children who attend school may be present.

d. In addition to these ten children, no more than two children who are receiving care on a part-time basis may be present.

e. No more than 12 children shall be present at any one time when an emergency school closing is in effect.

f. If more than eight children are present at any one time for a period of more than two hours, the provider shall be assisted by a department-approved assistant who is at least 14 years old, unless extra children are present as a result of an emergency school closing.

110.14(2) Provider qualifications.

a. The provider shall be at least 20 years old.

b. The provider shall have a high school diploma, GED, or documentation of current or previous enrollment in credit-based coursework from a postsecondary educational institution that is an accredited college or university.

- c. The provider shall either:
 - (1) Have two years of experience as a registered or nonregistered child care provider, or
 - (2) Have a child development associate credential or any two-year or four-year degree in a child care-related field and one year of experience as a registered or nonregistered child care home provider.

110.14(3) Facility requirements.

- a. The home shall have a minimum of 35 square feet of child-use floor space for each child in care indoors, and a minimum of 50 square feet per child in care outdoors.
- b. The home shall have a separate quiet area for sick children.
- c. The home shall have a minimum of two direct exits to the outside from the main floor.
 - (1) If the second level or the basement of the home is used for the provision of child care, other than the use of a restroom, each additional child-occupied floor shall have at least one direct exit to the outside in addition to one inside stairway.
 - (2) All exits shall terminate at grade level with permanent steps.
 - (3) A basement window may be used as an exit if the window can be opened from the inside without the use of tools and it provides a clear opening of not less than 20 inches in width, 24 inches in height, and 5.7 square feet in area. The bottom of the opening shall be not more than 44 inches above the floor, with permanent steps inside leading up to the window.
 - (4) Occupancy above the second floor shall not be permitted for child care.

[ARC 2647C, IAB 8/3/16, effective 10/1/16; ARC 5488C, IAB 3/10/21, effective 5/1/21]

441—110.15(237A) Additional requirements for child development home category C. In addition to the requirements in rule 441—110.8(237A), a provider requesting registration in child development home category C shall meet the following standards:

110.15(1) Limits on number of children in care.

- a. No more than 12 children not attending kindergarten or a higher grade level shall be present at any one time.
- b. Of these 12 children, no more than four children who are 24 months of age or younger shall be present at any one time. Whenever four children who are under the age of 18 months are in care, both providers shall be present.
- c. In addition to the 12 children not in school, no more than two children who attend school may be present for a period of less than two hours at any one time.
- d. In addition to these 14 children, no more than two children who are receiving care on a part-time basis may be present.
- e. No more than 16 children shall be present at any one time when an emergency school closing is in effect.
- f. If more than eight children are present, both providers shall be present. Each provider shall meet the provider qualifications for child development home category C.

110.15(2) Provider qualifications.

- a. One provider who meets the following qualifications must always be present:
 - (1) The provider shall be at least 21 years old.
 - (2) The provider shall have a high school diploma, GED, or documentation of current or previous enrollment in credit-based coursework from a postsecondary educational institution that is an accredited college or university.
 - (3) The provider shall either:
 1. Have five years of experience as a registered or nonregistered child care provider, or
 2. Have a child development associate credential or any two-year or four-year degree in a child care-related field and four years of experience as a registered or nonregistered child care home provider.
 - b. The coprovider shall meet the requirements of subrule 110.14(2).
 - c. No more than two named providers shall be allowed on a registration certificate.

110.15(3) Facility requirements.

- a. The home shall have a minimum of 35 square feet of child-use floor space for each child in care indoors, and a minimum of 50 square feet per child in care outdoors.

b. The home shall have a separate quiet area for sick children.

c. The home shall have a minimum of two direct exits to the outside from the main floor.

(1) If the second level or the basement of the home is used for the provision of child care, other than the use of a restroom, each additional child-occupied floor shall have at least one direct exit to the outside in addition to one inside stairway.

(2) All exits shall terminate at grade level with permanent steps.

(3) A basement window may be used as an exit if the window can be opened from the inside without the use of tools and it provides a clear opening of not less than 20 inches in width, 24 inches in height, and 5.7 square feet in area. The bottom of the opening shall be not more than 44 inches above the floor, with permanent steps inside leading up to the window.

(4) Occupancy above the second floor shall not be permitted for child care.

[ARC 2647C, IAB 8/3/16, effective 10/1/16; ARC 5488C, IAB 3/10/21, effective 5/1/21]

441—110.16(237A) Registration actions for nonpayment of child support. The department shall revoke or deny the issuance or renewal of a child development home registration upon the receipt of a certificate of noncompliance from the child support recovery unit of the department according to the procedures in Iowa Code chapter 252J. In addition to the procedures set forth in Iowa Code chapter 252J, the rules in this chapter shall apply.

110.16(1) Service of notice. The notice required by Iowa Code section 252J.8 shall be served upon the applicant or registrant by restricted certified mail, return receipt requested, or personal service in accordance with Iowa Rule of Civil Procedure 1.305. Alternatively, the applicant or registrant may accept service personally or through authorized counsel.

110.16(2) Effective date. The effective date of the revocation or denial of the registration 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.

110.16(3) Preparation of notice. The department director or designee of the director is authorized to prepare and serve the notice as required by Iowa Code section 252J.8 upon the applicant or registrant.

110.16(4) Responsibilities of registrants and applicants. Registrants and registrant applicants shall keep the department 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 department 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 the actions, and withdrawals of certificates of noncompliance by the child support recovery unit.

110.16(5) District court. A registrant or applicant may file an application with the district court within 30 days of service of a department notice pursuant to Iowa Code sections 252J.8 and 252J.9.

a. The filing of the application shall stay the department action until the department receives a court order lifting the stay, dismissing the action, or otherwise directing the department to proceed.

b. For purposes of determining the effective date of the revocation, or denial of the issuance or renewal of a registration, the department 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.

110.16(6) Procedure for notification. The department shall notify the applicant or registrant in writing through regular first-class mail, or such other means as the department deems appropriate in the circumstances, within ten days of the effective date of the revocation of a registration or the denial of the issuance or renewal of a registration, and shall similarly notify the applicant or registrant when the registration is issued, renewed, or reinstated following the department's receipt of a withdrawal of the certificate of noncompliance.

110.16(7) Appeal rights. Notwithstanding Iowa Code section 17A.18, the registrant does not have the right to a hearing regarding this issue but may request a court hearing pursuant to Iowa Code section 252J.9.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

441—110.17(237A) Prohibition from involvement with child care. If the department has prohibited a person or program from involvement with child care, that person or program shall not provide child care as a nonregistered child care home provider.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

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CHAPTER 120
CHILD CARE HOMES

PREAMBLE

This chapter establishes procedures for child care homes that have a child care assistance provider agreement to receive child care assistance funds. Included are application and renewal procedures, standards for providers, and procedures for compliance checks and complaint investigations.

[ARC 2648C, IAB 8/3/16, effective 10/1/16]

441—120.1(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 child’s parent, guardian, or custodian for periods of less than 24 hours per day per child on a regular basis. *“Child care”* shall not mean special activity programs that meet on a regular basis such as music or dance classes, organized athletics or sports programs, scouting programs, or hobby or craft classes or clubs.

“Child care facility” or *“facility”* means a child care center, a preschool, or a registered child development home.

“Child care home” means a person or program providing child care to five or fewer children at any one time that is not registered to provide child care under this chapter, as authorized under Iowa Code section 237A.3.

“Child development home” means a person or program registered under this chapter that may provide child care to six or more children at any one time.

“Department” means the department of human services.

“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.

“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 registration or is registered.
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.
5. The person will reside or resides in a child care home that is not registered but that receives public funding for providing child care.

“Provider” means the person or program that applies to receive payment from the child care assistance program to provide child care and is approved as a child care home.

“Relative” means grandparents, great grandparents, aunts, uncles, and siblings living in a separate residence.

“School” means kindergarten or a higher grade level.

“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.

[ARC 2648C, IAB 8/3/16, effective 10/1/16; ARC 3556C, IAB 1/3/18, effective 3/1/18]

441—120.2(237A) Application for payment. A provider shall apply for payment on Form 470-2890, Payment Application for Nonregistered Providers, provided by the department's local office or on the department's website. The provider shall also use Form 470-2890 to inform the department of any changes in circumstances that would affect the provider.

[ARC 2648C, IAB 8/3/16, effective 10/1/16]

441—120.3(237A) Renewal of agreement. Renewal of the child care assistance provider agreement shall be completed every 24 months. To request renewal, a provider shall submit Form 470-2890, Payment Application for Nonregistered Providers, and copies of certificates of training, which shall be retained in the file. The agreement renewal process shall include completion of child abuse, sex offender, and criminal record checks.

[ARC 2648C, IAB 8/3/16, effective 10/1/16]

441—120.4(237A) Compliance checks. An unannounced compliance visit shall be conducted not less than annually to check for compliance with health, safety, and fire standards. Completed evaluation checklists shall be placed in agency files.

[ARC 2648C, IAB 8/3/16, effective 10/1/16]

441—120.5(237A) Parental access. Parents shall be afforded unlimited access to their children and to the people caring for their children during the normal hours of operation or whenever their children are in the care of the child care home, unless parental contact is prohibited by court order.

[ARC 2648C, IAB 8/3/16, effective 10/1/16]

441—120.6(237A) Number of children. The number of children in a child care home shall conform to the following standards:

120.6(1) Limit. No more than five children shall receive care at any one time in the single-family residence.

120.6(2) Children counted. To determine the number of children cared for at any one time in a child care home, each child present in the child care home shall be considered to be receiving care unless the child is described by one of the following exceptions:

a. The child's parent, guardian, or custodian established or operates the child care home and either the child is attending school or the child receives child care full-time on a regular basis from another person.

b. The child has been present in the child care home for more than 72 consecutive hours and meets the requirements of the exception listed above as though the person who established or operates the child care home is the child's parent, guardian, or custodian.

[ARC 2648C, IAB 8/3/16, effective 10/1/16]

441—120.7(237A) Provider requirements.

120.7(1) Provider. The provider shall:

a. Give careful supervision at all times.

b. Exchange information with the parent of each child frequently to enhance the quality of care.

c. Give consistent, dependable care and be capable of handling emergencies.

d. Be present at all times except when emergencies occur or an absence is planned, at which time care shall be provided by a department-approved substitute. When an absence is planned, the provider shall give parents at least 24 hours' prior notice.

e. 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 the provider's ability to give careful supervision.

f. Be at least 18 years of age.

120.7(2) *Substitutes.* The provider shall assume responsibility for providing adequate and appropriate supervision at all times when children are in attendance. Any designated substitute shall have the same responsibility for providing adequate and appropriate supervision. Ultimate responsibility for supervision shall be with the provider.

- a. All standards in this chapter regarding supervision and care of children shall apply to substitutes.
- b. Except in emergency situations, the provider shall inform parents in advance of the planned use of a substitute.
- c. The substitute must be 18 years of age or older.
- d. Use of a substitute shall be limited to:
 - (1) No more than 25 hours per month.
 - (2) An additional period of up to two weeks in a 12-month period.
- e. The provider shall maintain a written record of the number of hours care is provided by a substitute, including the date of the care and the name of the substitute.

[ARC 2648C, IAB 8/3/16, effective 10/1/16]

441—120.8(237A) Standards. Conditions in the home shall be safe, sanitary, and free of hazards. The provider shall certify that the child care home meets the following minimum standards.

120.8(1) *Facility requirements.*

a. The home shall have a nonpay, working landline or mobile telephone with emergency numbers posted for police, fire, ambulance, and the poison information center. The number for each child's parent, for a responsible person who can be reached when the parent cannot, and for the child's physician shall be written on paper and readily accessible by the telephone. The home must prominently display all emergency information, and all travel vehicles must have a paper copy of emergency parent contact information.

b. Electrical wiring shall be maintained, and all accessible electrical outlets shall be tamper-resistant outlets or shall be safely capped. Electrical cords shall be properly used. Improper use includes the running of cords under rugs, over hooks, or through door openings or other use that has been known to be hazardous.

c. Combustible materials shall be kept a minimum of three feet away from furnaces, stoves, water heaters, and gas dryers.

d. Approved safety gates at stairways and doors shall be provided and used as needed.

e. Annual laboratory analysis of a private water supply shall be conducted to show satisfactory bacteriological quality. When children under the age of two are to be cared for, the analysis shall include a nitrate analysis. When private water supplies are determined unsuitable for drinking, commercially bottled water or water treated through a process approved by the health department or designee shall be provided.

f. A safety barrier shall surround any heating stove or heating element, in order to prevent burns.

g. The home shall have at least one 2A 10BC-rated fire extinguisher located in a visible and readily accessible place on each child-occupied floor.

h. The home shall have at least one single-station, battery-operated, UL-approved smoke detector in each child-occupied room and at the top of every stairway. Each smoke detector shall be installed according to manufacturer's recommendations. The provider shall test each smoke detector monthly and keep a record of testing for inspection purposes.

i. Smoking and the use of tobacco products shall be prohibited at all times in the home and in every vehicle in which children receiving care in the home are transported. Smoking and the use of tobacco products shall be prohibited in the outdoor play area during the home's hours of operation. "No smoking" signs shall be posted at every entrance of the child care home and in every vehicle used to transport children. All signs shall include:

- (1) The telephone number for reporting of complaints, and
- (2) The Internet address of the department of public health (www.iowasmokefreeair.gov).

j. Homes served by private sewer systems shall be in compliance with discharge restrictions identified at 567—Chapter 69. Discharge of untreated waste water from private sewage disposal systems

is prohibited. Compliance shall be verified by the local board of health at the time of renewal of the child care assistance provider agreement and new application.

k. A provider operating in a facility built before 1960 shall assess and control lead hazards before being issued an initial child care assistance provider agreement or a renewal of the provider agreement. To comply with this requirement, the provider shall:

(1) Conduct a visual assessment of the facility for lead hazards that exist in the form of chipping or peeling paint;

(2) Apply interim controls on any chipping or peeling paint found, using lead-safe work methods in accordance with and as defined by department of public health rules at 641—Chapters 69 and 70, unless a certified inspector as defined in 641—Chapter 70 determines that the paint is not lead-based paint; and

(3) Submit Form 470-4755, Lead Assessment and Control, as verification of the visual assessment and completion of interim controls, if necessary.

l. The child care home shall be located in a single-family residence that is owned, rented, or leased by the provider.

m. Any driver who transports children for any purpose shall have a valid driver's license and adequate motor vehicle insurance that authorizes the driver to operate the type of vehicle being driven. Child restraint devices shall be utilized in compliance with Iowa Code section 321.446.

n. Providers shall inform parents of the presence of any pet in the home.

(1) Each dog or cat in the household shall undergo an annual health examination by a licensed veterinarian. Acceptable veterinary examinations shall be documented on Form 470-5153, Veterinary Health Certificate. This examination shall verify that the animal's routine immunizations, particularly rabies, are current and that the animal shows no evidence of endoparasites (roundworms, hookworms, whipworms) and ectoparasites (fleas, mites, ticks, lice).

(2) Each pet bird in the household shall be purchased from a dealer licensed by the Iowa department of agriculture and land stewardship and shall be examined by a veterinarian to verify that the bird is free of infectious diseases. Acceptable veterinary examinations shall be documented on Form 470-5153, Veterinary Health Certificate. Children shall not handle pet birds.

(3) Aquariums shall be well maintained and installed in a manner that prevents children from accessing the water or pulling over a tank.

(4) All animal waste shall be immediately removed from the children's areas and properly disposed of. Children shall not perform any feeding or care of pets or cleanup of pet waste.

(5) No animals shall be allowed in the food preparation, food storage, or serving areas during food preparation and serving times.

o. Using an injury report form, the provider shall document all injuries that require first aid or medical care. The form shall be completed on the date of occurrence, shared with the parent, and maintained in the child's file.

p. Serious injuries.

(1) Serious injuries, as defined in Iowa Code section 702.18, that occur in a child care home or when a child is in the care of child care home staff shall be reported to the department within 24 hours of the incident.

(2) Serious injuries shall be documented and information maintained in the child's file as required by subrule 120.9(2).

120.8(2) *Use of outdoor space.*

a. A safe outdoor play area shall be maintained in good condition throughout the year. The play area shall be fenced off when located on a busy thoroughfare or near a hazard which may be injurious to a child and shall have both sunshine and shade areas. The play area shall be kept free from litter, rubbish, and flammable materials and shall be free from contamination by the drainage or ponding of sewage, household waste, or storm water.

b. When there is a swimming or wading pool on the premises:

(1) The wading pool shall be drained daily and shall be inaccessible to children when it is not in use.

(2) An aboveground or in-ground swimming pool that is not fenced shall be covered whenever the pool is not in use. The cover shall meet or exceed the ASTM International (formerly known as the American Society for Testing and Materials) specification intended to reduce the risk of drowning by inhibiting access to the water by children under five years of age.

(3) An uncovered aboveground swimming pool shall be enclosed with an approved fence that is nonclimbable and is at least four feet high.

(4) An uncovered in-ground swimming pool shall be enclosed with an approved fence that is nonclimbable and is at least four feet high and flush with the ground.

c. If children are allowed to use an aboveground or in-ground swimming pool:

(1) Written permission from parents shall be available for review.

(2) Equipment needed to rescue a child or adult shall be readily accessible.

(3) The child care provider shall accompany the children and provide constant supervision while the children use the pool.

(4) The child care provider shall complete training in cardiopulmonary resuscitation for infants, toddlers, and children, according to the criteria of the American Red Cross or the American Heart Association.

120.8(3) Medications and hazardous materials.

a. All medicines and poisonous, toxic, or otherwise unsafe materials shall be secured from access by a child.

b. A first-aid kit shall be available and easily accessible whenever children are in the child care home, in the outdoor play area, in vehicles used to transport children, 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. The kit shall, at a minimum, include adhesive bandages, bottled water, disposable tweezers, and disposable plastic gloves.

c. Medications shall be given only with the parent's or doctor's written authorization. Each prescribed medication shall be accompanied by a physician's or pharmacist's direction. Both nonprescription and prescription medications shall be in the original container with directions intact and labeled with the child's name. All medications shall be stored properly and, when refrigeration is required, shall be stored in a separate, covered container so as to prevent contamination of food or other medications. All medications shall be stored so they are inaccessible to children. Any medication administered to a child shall be recorded, and the record shall indicate the name of the medication, the date and time of administration, and the amount administered.

d. Medications shall not be provided to a child if the provider has not completed preservice/orientation training that includes medication administration.

e. The provider shall establish procedures related to infectious disease control and handling of any bodily excrement or discharge, including blood and breast milk. Soiled diapers shall be stored in containers separate from other waste.

120.8(4) Emergency plans. Emergency plans in case of man-made or natural disaster shall be written and posted by the primary and secondary exits. The plans shall clearly map building evacuation routes and tornado and flood shelter areas.

a. Fire and tornado drills shall be practiced monthly, and the provider shall keep documentation evidencing compliance with monthly practice on file.

b. The provider must have procedures in place for the following:

(1) Evacuation to safely leave the facility.

(2) Relocation to a common, safe location after evacuation.

(3) Shelter-in-place to take immediate shelter where the child is when it is unsafe to leave that location due to the emergent issue.

(4) Lockdown to protect children and providers from an external situation.

(5) Communication and plans for reunification with families.

(6) Continuity of operations.

(7) To address the needs of individual children, including those with functional or access needs.

120.8(5) Safe sleep.

a. The provider shall follow safe sleep practices as recommended by the American Academy of Pediatrics for infants under the age of one. Infant sleep shall conform to the following standards:

- (1) Infants shall always be placed on their backs for sleep.
- (2) Infants shall be placed on a firm mattress with a tight fitted sheet that meets U.S. Consumer Product Safety Commission federal standards.
- (3) Infants shall not be allowed to sleep on a bed, sofa, air mattress or other soft surface.
- (4) No toys, soft objects, stuffed animals, pillows, bumper pads, blankets, or loose bedding shall be allowed in the sleeping area with the infant.
- (5) No co-sleeping shall be allowed.
- (6) Sleeping infants shall be actively observed by sight and sound.
- (7) If an alternate sleeping position is needed, a signed physician or physician assistant authorization with statement of medical reason is required.

b. No child shall be allowed to sleep in any item not designed for sleeping including, but not limited to, an infant seat, car seat, swing, or bouncy seat.

c. 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 ASTM International 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 home shall maintain 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.

d. All items used for sleeping must be used in compliance with manufacturer standards for age and weight of the child.

120.8(6) Discipline. Discipline shall conform to the following standards:

- a. Corporal punishment, including spanking, shaking and slapping, shall not be used.
- b. Punishment that is humiliating or frightening or that causes pain or discomfort to the child shall not be used.
- c. Punishment shall not be administered because of a child's illness, or progress or lack of progress in toilet training, nor shall punishment or threat of punishment be associated 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.
- e. Discipline shall be designed to help the child develop self-control, self-esteem, and respect for the rights of others.

120.8(7) Meals and snacks.

- a. Regular meals and snacks that are well-balanced and nourishing shall be provided.
- b. Children may bring food to the child care home for their own consumption but shall not be required to provide their own food.
- c. Clean, sanitary drinking water shall be readily available to children in indoor and outdoor areas, throughout the day.

[ARC 2648C, IAB 8/3/16, effective 10/1/16; ARC 3096C, IAB 6/7/17, effective 8/1/17; ARC 3556C, IAB 1/3/18, effective 3/1/18; ARC 5488C, IAB 3/10/21, effective 5/1/21]

441—120.9(237A) Children's files.

120.9(1) An individual file for each child shall be maintained and updated annually or when the provider becomes aware of changes.

120.9(2) The file shall contain:

- a. Identifying information including, at a minimum, the child's name and birth date; the parent's name, address and telephone number; the special needs of the child; and the parent's work address and telephone number.
- b. Emergency contact information including, at a minimum, where the parent can be reached, the name, street address, city and telephone number of the child's regular source of health care, and the name, telephone number, and relationship to the child of another adult available in case of emergency.

- c.* A signed medical consent from the parent authorizing emergency medical and dental treatment.
- d.* An admission physical examination report signed by a licensed physician or the designee in a clinic supervised by a licensed physician.
- e.* A statement of health condition signed by a physician or designee submitted annually from the date of the admission physical examination. For a child who is five years of age or older and enrolled in school, a statement of health status signed by the parent or legal guardian may be substituted for the physician statement.
- f.* A list that is signed by the parent and names persons authorized to pick up the child. The authorization shall include the name, telephone number, and relationship of the authorized person to the child.
- g.* A signed and dated immunization certificate provided by the Iowa department of public health. For the school-age child, a copy of the most recent immunization record shall be acceptable.
- h.* For any child with allergies, a written emergency plan in case of an allergic reaction. A copy of this information shall accompany the child if the child leaves the premises.
- i.* Written permission from the parent for the child to attend activities away from the child care home. The permission shall include:
 - (1) Times of departure and arrival.
 - (2) Destination.
 - (3) Names of persons who will be responsible for the child.
- j.* If the child meets the definition of homelessness as defined by Section 725(2) of the McKinney Vento Homeless Education Assistance Act, the family shall receive a 60-day grace period to obtain medical documentation.

[ARC 2648C, IAB 8/3/16, effective 10/1/16; ARC 3095C, IAB 6/7/17, effective 8/1/17]

441—120.10(237A) Professional development.

120.10(1) Prior to the issuance of a provider agreement, the provider shall complete minimum health and safety trainings, approved by the department, in all of the following content areas:

- a.* Prevention and control of infectious disease, including immunizations.
- b.* Prevention of sudden infant death syndrome and use of safe sleep practices.
- c.* Administration of medication, consistent with standards for parental consent.
- d.* Prevention of and response to emergencies due to food and allergic reactions.
- e.* Building and physical-premises safety, including identification of and protection from hazards that can cause bodily injury, such as electrical hazards, bodies of water, and vehicular traffic.
- f.* Prevention of shaken baby syndrome and abusive head trauma.
- g.* Emergency preparedness and response planning for emergencies resulting from a natural disaster or a human-caused event.
- h.* Handling and storage of hazardous materials and the appropriate disposal of biocontaminants.
- i.* Precautions in transporting children.
- j.* Child development, on or after August 1, 2017.

120.10(2) Prior to issuance of a provider agreement, the provider shall complete two hours of Iowa's training for mandatory reporting of child abuse as required by Iowa Code section 232.69. The provider shall maintain a valid certificate indicating expiration date.

120.10(3) Prior to issuance of a provider agreement, the provider shall complete first-aid and cardiopulmonary resuscitation (CPR) training that meets the following requirements:

- a.* Training shall be provided by a nationally recognized training organization, such as the American Red Cross, American Heart Association, National Safety Council, American Safety and Health Institute or MEDIC First Aid or by an equivalent trainer using curriculum approved by the department.
- b.* CPR training shall include certification in infant and child CPR.
- c.* The provider shall maintain a valid certificate indicating the date of first-aid training and the expiration date.

d. The provider shall maintain a valid certificate indicating the date of CPR training and the expiration date.

120.10(4) Minimum health and safety training may be required if content has significant changes which warrant that the training be renewed.

120.10(5) Approved substitutes must have certification or other documentation that minimum health and safety training has been completed in compliance with 441—subrule 110.10(1) within three months of a substitute’s hiring or before a substitute provides care, whichever occurs first.

120.10(6) During each two-year provider agreement period, the provider shall receive a minimum of six hours of training. A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

a. Training shall be completed 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.

b. Training identified in subrule 120.10(1) may be counted toward the total six hours of required training only at the initial time in which the training is received.

c. A child care home provider operating under this chapter that meets the definition of “relative” as defined in rule 441—120.1(237A) shall be exempt from the training requirements under this subrule.

120.10(7) Approved training.

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 by 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, American Heart Association, National Safety Council, American Safety and Health Institute 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 (CACFP) 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.

(14) Organizations that are certified by the International Association for Continuing Education and Training (IACET).

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 120.10(7) “a” or an entity approved under paragraph 120.10(7) “h.”

c. Approved training shall be made available to Iowa child care providers through the child care provider training registry.

d. Training received in a group setting may include distance learning opportunities, such as training conducted over the Iowa communications network, online courses, or web conferencing (webinars) if:

- (1) The training meets the requirements in subrule 120.10(8);
- (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.

e. The department will not approve more than eight hours of training delivered in a single day.

f. The department may randomly monitor any state-approved training for quality control purposes.

g. Training conducted with the provider either during the hours of operation of the facility, provider lunch hours, or while children are resting must not diminish the required ratio coverage. The provider shall not be actively engaged in care and supervision and simultaneously participate in training.

h. A training organization not approved by the department may submit a request for review 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.

120.10(8) Elements of 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 teacher-student interaction and timely feedback, including questions and answers and with evaluation of learning.

d. For each participant, a certificate of training 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.

[ARC 2648C, IAB 8/3/16, effective 10/1/16; ARC 3095C, IAB 6/7/17, effective 8/1/17; ARC 3556C, IAB 1/3/18, effective 3/1/18; ARC 4753C, IAB 11/6/19, effective 12/11/19]

441—120.11(237A) Child care assistance provider agreement decision. The department shall issue Form 470-3871, Child Care Assistance Provider Agreement, when an applicant meets all requirements for a child care home. The department shall maintain a current list of child care homes as a referral service to the community.

120.11(1) A provider agreement shall be denied or canceled if the department finds a hazard to the safety and well-being of a child and the provider cannot correct or refuses to correct the hazard, even though the hazard may not have been specifically listed under these rules. The provider agreement may also be denied or canceled if the department determines that the provider has failed to comply with standards imposed by law and rules found in this chapter or at 441—Chapter 170.

120.11(2) Record of all denials or cancellations of provider agreements and the documentation of reasons for denying or canceling the agreement shall be kept in an open file.

120.11(3) Record checks.

a. Applicability. The department shall conduct Iowa criminal history record and child abuse record checks for each provider, substitute or staff member, anyone living in the home who is 14 years of age or older, and anyone having access to a child when the child is alone. The department shall conduct national criminal history record checks, based on fingerprints, for each provider, substitute or staff member, anyone living in the home who is 18 years of age or older, and anyone 18 years of age or older having access to a child when the child is alone. In accordance with Iowa Code section 726.23, minors under the age of 18 will not be subject to the fingerprint requirement.

(1) The purpose of these record checks is to determine whether the person has committed a transgression that prohibits or limits the person's involvement with child care.

(2) The department may also conduct criminal history record and child abuse record checks in other states and may conduct dependent adult abuse, sex offender registry, and other public or civil offense record checks in Iowa or other states.

(3) Child care assistance provider agreements shall not be issued until the results of all state and national record checks have been received and, when necessary, evaluated.

b. Authorization. The person subject to record checks shall complete the Iowa department of human services record check authorization form; Form DCI-45, Waiver Agreement; Form FD-258, Federal Fingerprint Card; 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 history records shall be completed before the person's involvement with child care. Iowa records checks shall be repeated at a minimum of every two years and when the department or the provider becomes aware of any possible transgressions. The department is responsible for the cost of conducting the Iowa records checks.

d. National criminal history record checks. Fingerprint-based checks of national criminal history records shall also be completed before a person's involvement with child care. This requirement shall be required for an initial application or a renewal application. The national criminal history record check shall be repeated for each person subject to the check every four years and when the department or provider becomes aware of any new transgressions committed by that person in another state. The department is responsible for the cost of conducting the national criminal history record check.

(1) The provider is responsible for any costs associated with the taking (rolling) of fingerprints of all persons subject to record checks and for submitting the fingerprints to the department so the national criminal history record check can be completed. Fingerprints may be taken (rolled) by law enforcement agencies or by agencies or companies that specialize in taking (rolling) fingerprints.

(2) The department shall provide fingerprints to the department of public safety no later than ten business days after receipt of the fingerprint cards. The department shall submit the fingerprints on forms or in a manner allowed by the department of public safety.

(3) The department may rely on the results of previously conducted national criminal history record checks when a person subject to a record check in one child development home or child care home submits a request for involvement with child care in another child development home or child care home, so long as the person's national criminal history record check is within the allowable four-year time frame. All initial or new applications shall require a new national criminal history record check.

e. Mandatory prohibition. A person with any of 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) A requirement to be listed on any state sex offender registry or the national sex offender registry.
- (3) Any of the following felony convictions:
 1. Child endangerment or neglect or abandonment of a dependent person.
 2. Domestic abuse.
 3. Crime against a child including, but not limited to, sexual exploitation of a minor.

4. Forcible felony.
5. Arson.
- (4) A record of a misdemeanor conviction of a crime against a child that constitutes one of the following offenses:
 1. Child abuse.
 2. Child endangerment.
 3. Sexual assault.
 4. Child pornography.
- (5) If a person subject to a record check refuses to consent to a record check, the person shall be prohibited from involvement with child care.
- (6) If a person has been convicted of a crime and makes what the person knows to be a false statement of material fact in connection with the conviction or record check, the person shall be prohibited from involvement with child care.
 - f. Mandatory time-limited prohibition.*
 - (1) A person with the following conviction or founded abuse report 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.
 2. Founded abuse that was determined to be physical abuse.
 - (2) After the five-year prohibition period (from the date of the conviction or the founded abuse report) as defined in subparagraph 120.11(3)“f”(1), the person may request the department to perform an evaluation under paragraph 120.11(3)“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 120.11(3)“f”(2), the department shall evaluate the transgression and make a decision about the person’s involvement with child care.
 - (1) The person with the transgression shall complete and return the record check evaluation form 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 within ten calendar days of the date on the form shall result in denial or revocation of the child care assistance provider agreement.
 - (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.
 - (4) When a person subject to a record check has a transgression that has been determined in a previous evaluation not to warrant prohibition of the person’s involvement with child care and the person has no subsequent transgressions, an exemption from reevaluation of the latest record check is authorized. The person may commence employment with another child care facility in accordance with the department’s previous evaluation. The exemption is subject to all of the following conditions:
 1. The position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.
 2. Any restrictions placed on the person’s employment by the department in the previous evaluation shall remain applicable in the person’s subsequent employment.
 3. The person subject to the record check has maintained a copy of the previous evaluation and provides the evaluation to the subsequent employer or the previous employer provides to the subsequent employer the previous evaluation from the person’s personnel file pursuant to the person’s authorization.

If a physical copy of the previous evaluation is not provided to the subsequent employer, the record check shall be reevaluated.

4. The subsequent employer may request a reevaluation of the record check and may employ the person while the reevaluation is being performed.

h. Evaluation decision. 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 or corrective action plan.

(1) Within 30 calendar days of receipt of a completed record check evaluation, the department shall make a decision on the person's involvement with child care.

(2) Within 30 calendar days of receipt of a completed record check evaluation, the department shall mail to the person subject to an evaluation a record check decision that explains the decision reached regarding the evaluation of the transgression and a notice of decision: child care.

(3) The department shall issue a notice of decision: child care prohibiting involvement with child care when the person subject to an evaluation fails to complete the record check evaluation within the ten-calendar-day time frame.

(4) If the department determines, through the record check evaluation process, 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.

(5) The department may permit a person who is evaluated to maintain involvement with child care if the person complies with the department's conditions relating to the person's involvement with child care, which may include completion of additional training or an individually designed corrective action plan, or both. For an employee of a provider, these conditional requirements shall be developed with the provider. All conditions placed on a person's involvement with child care shall be communicated, in writing, to both the person subject to the evaluation and the provider.

(6) The department shall reevaluate any transgressions where a state or federal law change requires different considerations of the transgression than had been previously applied.

i. Notice to parents of abuse in care. If there has been founded child abuse committed by an owner, director, or staff member of the child care facility or child care home, the department's administrator shall notify the parents, guardians, and legal custodians of each child for whom the facility or child care home provides care.

(1) The child care facility or child care home shall cooperate with the department in providing the names and addresses of the parent, guardian, or custodian of each child for whom the facility provides child care.

(2) This information shall be provided to the department within ten calendar days from the date of the initial request.

(3) Failure or refusal to provide the requested information may result in cancellation of the provider agreement.

120.11(4) Required notifications to the department.

a. The provider shall, within ten days, notify the department of any of the following:

- (1) Changes in substitutes;
- (2) Changes in household membership;
- (3) Address changes; and
- (4) Criminal convictions.

b. No substitute shall be utilized in the care of children and no person shall be permitted to reside in the household until approved by the department.

c. If the provider does not notify the department of changes within ten days, the provider may be subject to revocation of the provider's child care assistance provider agreement or to recoupment of child care assistance provided, or both.

[ARC 2648C, IAB 8/3/16, effective 10/1/16; ARC 4114C, IAB 11/7/18, effective 1/1/19]

441—120.12(237A) Complaints. The department shall conduct an on-site visit when a complaint is received.

120.12(1) After each complaint visit, the department shall document whether the child care home was in compliance with requirements.

120.12(2) The written documentation of the department's conclusion as to whether the child care home was in compliance with requirements shall be available to the public. However, the identity of all complainants shall be confidential, unless expressly waived by the complainant.

[ARC 2648C, IAB 8/3/16, effective 10/1/16]

441—120.13(237A) Prohibition from involvement with child care. If the department has prohibited a person or program from involvement with child care, that person or program shall not provide child care as a nonregistered child care home provider.

[ARC 2648C, IAB 8/3/16, effective 10/1/16]

These rules are intended to implement Iowa Code section 237A.12.

[Filed ARC 2648C (Notice ARC 2552C, IAB 5/25/16), IAB 8/3/16, effective 10/1/16]

[Filed ARC 3095C (Notice ARC 2998C, IAB 3/29/17), IAB 6/7/17, effective 8/1/17]

[Filed ARC 3096C (Notice ARC 2997C, IAB 3/29/17), IAB 6/7/17, effective 8/1/17]

[Filed ARC 3556C (Notice ARC 3436C, IAB 11/8/17), IAB 1/3/18, effective 3/1/18]

[Filed ARC 4114C (Notice ARC 3970C, IAB 8/29/18), IAB 11/7/18, effective 1/1/19]

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[Filed ARC 5488C (Notice ARC 5337C, IAB 12/16/20), IAB 3/10/21, effective 5/1/21]

CHAPTER 4
EMPLOYERS

[Prior to 6/9/04, see 581—Ch 21]

495—4.1(97B) Covered employers.

4.1(1) Definition. All public employers in the state of Iowa, its cities, counties, townships, agencies, political subdivisions, instrumentalities and public schools are required to participate in IPERS. For the purposes of these rules, the following definitions also apply:

a. "Political subdivision" means a geographic area or territorial division of the state which has responsibility for certain governmental functions. Political subdivisions are characterized by public election of officers and taxing powers. The following examples are representative: cities, municipalities, counties, townships, schools and school districts, drainage and levee districts, and utilities.

b. "Instrumentality of the state or a political subdivision" means an independent entity that is organized to carry on some specific function of government. Public instrumentalities are created by some form of governmental body, including federal and state statutes and regulations, and are characterized by being under the control of a governmental body. Such control may include final budgetary authorization, general policy development, appointment of a board by a governmental body, and allocation of funds.

c. "Public agency" means state agencies and agencies of political subdivisions. Representative examples include an executive board, commission, bureau, division, office, or department of the state or a political subdivision.

d. Effective July 1, 1994, the definition of employer includes an area agency on aging that does not offer an alternative plan to all of its employees that is qualified under the federal Internal Revenue Code.

Covered employers include, but are not limited to: the state of Iowa and its administrative agencies; counties, including their hospitals and county homes; cities, including their hospitals, park boards and commissions; recreation commissions; townships; public libraries; cemetery associations; municipal utilities including waterworks, gasworks, electric light and power; school districts including their lunch and activity programs; state colleges and universities; and state hospitals and institutions.

An entity not already reporting to IPERS which meets the conditions for becoming an IPERS-covered employer shall immediately contact IPERS to provide notice which includes the name and address of the entity and other information required by IPERS. If, after review of this information, IPERS determines that the entity should be enrolled as a covered employer, IPERS will notify the entity and provide an IPERS account number for the entity to use when submitting information. IPERS shall not be required to provide benefits otherwise available under Iowa Code chapter 97B for periods of service prior to the effective date for which IPERS actually approves the entity for coverage, unless the employer agrees to pay the full actuarial cost of providing such benefits.

An employer may request a revised beginning date for its status as a covered employer. The employer must submit acceptable proof to IPERS that its status as a covered employer began earlier than the date previously provided. In such case, the employer shall provide IPERS coverage retroactively to all employees providing services to that employer on or after the revised beginning date and shall pay all actuarial costs.

4.1(2) Name change. Any employer which has a change of name, address, title of the employer, its reporting official or any other identifying information shall immediately give notice in writing to IPERS. The notice shall provide IPERS with the following information:

- a.* Former name;
- b.* Former address;
- c.* IPERS account number;
- d.* New name, address, and telephone number of the employer;
- e.* Reason for the change if other than a change of reporting official; and
- f.* Effective date of the change.

4.1(3) Termination. Any employer which terminates or is dissolved for any reason shall provide IPERS with the following:

- a. Complete name and address of the dissolved entity;
- b. Assigned IPERS account number;
- c. Last date on which wages were paid;
- d. Date on which the entity dissolved;
- e. Reason for the dissolution;
- f. Whether or not the entity expects to pay wages in the future;
- g. Whether the entity is being absorbed by another covered employer;
- h. Name and address of absorbing employer if applicable; and
- i. Name and address of employer that will retain the records of the dissolved entity.

4.1(4) Reports of dissolved or absorbed employers. An employer that has been dissolved or entirely absorbed by another employer is required to file a monthly report with IPERS through the effective date on which it was dissolved or absorbed. Any wages paid after this date are reported under the account number assigned to the new or successor employer, if any.

4.1(5) IPERS account number. Each employer is assigned an IPERS account number. This number should be used on all correspondence and reporting forms directed to IPERS.

4.1(6) Patient advocates. For patient advocates employed under Iowa Code section 229.19, the county or counties for which services are performed shall be treated as the covered employer(s) of such individuals, and each such employer is responsible for forwarding reports and for withholding and forwarding the applicable IPERS contributions on wages paid by each employer.

[ARC 3684C, IAB 3/14/18, effective 4/18/18]

495—4.2(97B) Records to be kept by the employer.

4.2(1) General. Each employer shall maintain records to show the information hereinafter indicated. Records shall be kept in the form and manner prescribed by IPERS. Records shall be open to inspection and may be copied by IPERS and its authorized representatives at any reasonable time.

4.2(2) Required information. Records shall show with respect to each employee:

- a. Employee's name, address, gender, and social security account number, and other demographic information that may be required;
- b. Each date the employee was paid wages or other wage equivalent (e.g., room, board);
- c. Total amount of wages paid on each date including noncash wage equivalents;
- d. Total amount of wages including wage equivalents on which IPERS contributions are payable;
- e. Amount withheld from wages or wage equivalents for the employee's share of IPERS contributions; and
- f. Effective January 1, 1995, records will show, with respect to each employee, member contributions picked up by the employer.

4.2(3) Reports.

a. Each employer shall make reports as IPERS may require and shall comply with the instructions provided by IPERS for the reports.

b. Effective July 1, 2021, employers shall report the termination date and date of final paycheck for all terminating employees to IPERS with the final wage report for such employee. This report shall contain the employee's last-known mailing address and such other information as IPERS might require.

c. The Iowa department of administrative services and the Iowa department of corrections shall notify IPERS prior to adding additional job classifications to the protection occupation class. The notification shall include the effective date, names and social security numbers of the employees involved.

4.2(4) Fees. IPERS may assess to the employer a fee for administrative costs as described in subrule 4.3(6).

[ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 5489C, IAB 3/10/21, effective 4/14/21]

495—4.3(97B) Wage reporting and payment of contributions by employers.

4.3(1) Payment of contributions. For wages paid on or after July 1, 2008, all covered employers are required to pay contributions on a monthly basis. Upon enrollment as an IPERS-covered employer,

the employer shall receive the appropriate forms and instructions from IPERS to submit contributions. IPERS will provide monthly statements to each employer.

IPERS accepts the payment of contributions through electronic funds transfer. Payments utilizing the electronic funds transfer system shall be made according to the procedure described in subrule 4.3(3).

IPERS accepts the payment of contributions using checks and remittance advice forms. Employers filing monthly employer remittance advice forms on paper for two or more employers shall attach the checks to each remittance form. Checks shall be made payable to the Iowa Public Employees' Retirement System and mailed with the employer remittance advice form to IPERS, P.O. Box 9117, Des Moines, Iowa 50306-9117. Effective August 1, 2008, such payments and reports shall be subject to a fee as described in subrule 4.3(6).

4.3(2) *Wage reports.* For wages paid on or after July 1, 2008, all IPERS-covered employers are required to file wage reports on a monthly basis. IPERS will provide the forms and instructions for wage reporting to employers. Each wage report must include the required information for all employees who earned reportable wages or wage equivalents under IPERS. The reports must be received by IPERS on or before the fifteenth day of the month following the month in which the wages were paid. If the fifteenth day falls on a weekend or state-observed holiday, the wage report is due on the next regularly scheduled business day.

Effective August 1, 2008, IPERS shall accept wage reports electronically via IPERS' employer self-service Internet application or as a paper report. However, for those employers submitting reports other than via IPERS' employer self-service Internet application, IPERS shall charge a fee as described in subrule 4.3(6).

4.3(3) *Deadlines for payment of contributions.*

a. Contributions must be paid monthly and must be received by IPERS on or before the fifteenth day of the month following the month in which wages were paid. If the fifteenth day falls on a weekend or state-observed holiday, the contribution is due on the next regularly scheduled business day.

b. For employers paying contributions by electronic funds transfer, wage reports and contributions may be submitted at the same time.

4.3(4) *Request for time extension.* A request for an extension of time to file a wage report or pay a contribution may be granted by IPERS for good cause if a request is made before the due date, but no extension shall exceed 15 days beyond the due date. If an employer that has been granted an extension fails to submit the wage report or pay the contribution on or before the end of the extension period, the applicable interest and fees shall be charged and paid from the original due date as if no extension had been granted. If the fifteenth day falls on a weekend or state-observed holiday, the contribution or wage report is due on the next regularly scheduled business day.

To establish good cause for an extension of time to file a wage report or pay contributions, the employer must show that the delinquency was not due to mere negligence, carelessness or inattention. The employer must affirmatively show that it did not file the wage report or timely pay a contribution because of some occurrence beyond the control of the employer.

4.3(5) *No reportable wages.* When an employer has no reportable wages during the applicable reporting period, the wage reporting document shall be filed according to subrule 4.3(2). Even if there are no reportable wages, the employer's account is considered delinquent for the reporting period and is subject to a fee until the report is filed. However, if the employer has notified IPERS on or before the due date that there are no wages to report, IPERS will adjust the due date, and no fee will be charged.

4.3(6) *Fees for noncompliance.* IPERS is authorized to impose reasonable fees on employers that do not file wage reports through the IPERS' employer self-service Internet application as described in subrule 4.3(2), that fail to timely file accurate wage reports, or that fail to pay contributions when due pursuant to subrule 4.3(3).

For submissions filed on or after August 1, 2008, IPERS shall charge employers a processing fee of \$20 plus 25 cents per employee for late submissions and manual processing of wage reports by IPERS. Employers that are late or that do not use IPERS' employer self-service Internet application may be charged both fees. In addition, if a fee for noncompliance is not paid by the fifteenth day of the month after the fee is assessed, the fee will accrue interest daily at the interest rate provided in Iowa Code

sections 97B.9 and 97B.70. No fee will be charged on late contributions received as a result of a wage adjustment, but interest on the amount due will be charged until paid in full.

If the due date for a fee falls on a weekend or state-observed holiday, the due date shall be the next regularly scheduled business day.

4.3(7) *Erroneously reported wages for employees not covered under IPERS.* Employers that erroneously report wages for employees who are not eligible for coverage under IPERS may file an IPERS wage reporting adjustment form. IPERS shall return a warrant or issue a credit for both the employer and employee contributions made in error. The employer is responsible for returning the employees' share and for filing corrected federal and state wage reporting forms. Adjustments in such cases will be reported on the employer's monthly statement. Under no circumstance shall the employer adjust these wages by underreporting wages on a future periodic wage reporting document. Wages shall never be reported as a negative amount. An employer that completes the employer portion of an employee's request for a refund on an IPERS refund application form will not be permitted to file a periodic wage reporting adjustment form for that employee for the same time period. No fee will be assessed to employers that correct information as provided under this subrule.

4.3(8) *Contributions paid on wages in excess of the annual covered wage maximum.* For wages paid on or after July 1, 2008, whenever IPERS determines that an employee's wages will exceed the annual maximum established under Section 401(a)(17)(A) and the cost-of-living adjustments to that maximum permitted under Section 401(a)(17)(B) of the Internal Revenue Code during a given month, IPERS shall notify the applicable employer and shall return the related excess contributions. IPERS will detail on the monthly report those employees for whom wages were reported in excess of the covered wage ceiling. The employer is responsible for returning the employee's share of excess contributions and making the applicable tax corrections.

4.3(9) *Termination within less than six months of the date of employment.* If an employee hired for permanent employment terminates within six months of the date of employment, the employer may file an IPERS form for reporting adjustments to receive a warrant or a credit, as elected by the employer, for both the employer's and employee's portions of the contributions. It is the responsibility of the employer to return the employee's share. "Termination within less than six months of the date of employment" means employment is terminated prior to the day before the employee's six-month anniversary date. For example, an employee hired on February 10 whose last day is August 8 would be treated as having resigned within less than six months. An employee hired on February 10 whose last day is August 9 (the day before the six-month anniversary date, August 10) would be treated as having worked six months and would be eligible for a refund.

4.3(10) *Reinstatement following an employment dispute.* Employees who are reinstated following an employment dispute may restore membership service credit as described in 495—9.5(97B).

[ARC 9397B, IAB 2/23/11, effective 3/30/11; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 3684C, IAB 3/14/18, effective 4/18/18]

495—4.4(97B) *Accrual of interest and application of employer payments.* Interest or charges as provided under Iowa Code section 97B.9 shall accrue on all employer payments not received by IPERS by the due date, except that interest or charges may be waived by IPERS if the employer requests an extension of time under subrule 4.3(4) prior to the due date. Effective August 1, 2008, employers that remit late contributions shall be charged a minimum of \$20 or interest at the rate provided in Iowa Code section 97B.70, whichever is greater. No fee will be charged on late contributions received as a result of a wage adjustment, but interest on the amount due will be charged until paid in full. Payments received from employers having unpaid account balances shall first be applied to the oldest outstanding balance.

495—4.5(97B) *Credit memos voided.* Rescinded IAB 3/26/08, effective 4/30/08.

495—4.6(97B) *Contribution rates.* The following contribution rate schedule, payable on the covered wage of the member, is determined by the position or classification and the occupation class code of the member.

4.6(1) *Contribution rates for regular class members.*

a. The following contribution rates were established by the Iowa legislature for all regular class members for the indicated periods:

	Effective July 1, 2007	Effective July 1, 2008	Effective July 1, 2009	Effective July 1, 2010	Effective July 1, 2011
Combined rate	9.95%	10.45%	10.95%	11.45%	13.45%
Employer	6.05%	6.35%	6.65%	6.95%	8.07%
Employee	3.90%	4.10%	4.30%	4.50%	5.38%

b. Effective July 1, 2012, and every year thereafter, the contribution rates for regular members shall be publicly declared by IPERS staff no later than the preceding December as determined by the annual valuation of the preceding fiscal year. The public declaration of contribution rates will be followed by rule making that will include a notice and comment period and that will become effective July 1 of the next fiscal year. Contribution rates for regular members are as follows.

	Effective July 1, 2017	Effective July 1, 2018	Effective July 1, 2019	Effective July 1, 2020	Effective July 1, 2021
Combined rate	14.88%	15.73%	15.73%	15.73%	15.73%
Employer	8.93%	9.44%	9.44%	9.44%	9.44%
Employee	5.95%	6.29%	6.29%	6.29%	6.29%

4.6(2) Contribution rates for sheriffs and deputy sheriffs are as follows.

	Effective July 1, 2017	Effective July 1, 2018	Effective July 1, 2019	Effective July 1, 2020	Effective July 1, 2021
Combined rate	18.76%	19.52%	19.02%	18.52%	18.02%
Employer	9.38%	9.76%	9.51%	9.26%	9.01%
Employee	9.38%	9.76%	9.51%	9.26%	9.01%

4.6(3) Contribution rates for protection occupations are as follows.

	Effective July 1, 2017	Effective July 1, 2018	Effective July 1, 2019	Effective July 1, 2020	Effective July 1, 2021
Combined rate	16.40%	17.02%	16.52%	16.02%	15.52%
Employer	9.84%	10.21%	9.91%	9.61%	9.31%
Employee	6.56%	6.81%	6.61%	6.41%	6.21%

4.6(4) Members employed in a “protection occupation” shall include:

a. Conservation peace officers. Effective July 1, 2002, all conservation peace officers, state and county, as described in Iowa Code sections 350.5 and 456A.13.

b. Effective July 1, 1994, a marshal in a city not covered under Iowa Code chapter 400 or a firefighter or police officer of a city not participating under Iowa Code chapter 410 or 411. (See employee classifications in rule 495—5.1(97B).) Effective January 1, 1995, part-time police officers shall be included.

c. Correctional officers as provided for in Iowa Code section 97B.49B. Employees who, prior to December 22, 1989, were in a “correctional officer” position but whose position is found to no longer meet this definition on or after that date shall retain coverage, but only for as long as the employee is in that position or another “correctional officer” position that meets this definition. Movement to a position that does not meet this definition shall cancel “protection occupation” coverage.

d. Airport firefighters employed by the military division of the department of public defense (airport firefighters). Effective July 1, 2004, airport firefighters become part of and shall make the same contributions as the other members covered under Iowa Code section 97B.49B. From July 1, 1994, through June 30, 2004, airport firefighters were grouped with and made the same contributions

as sheriffs and deputy sheriffs. From July 1, 1988, through June 30, 1994, airport firefighters were grouped with and made the same contributions as the other members covered under Iowa Code section 97B.49B. From July 1, 1986, through June 30, 1988, airport firefighters were a separate protection occupation group and made contributions at a rate calculated for members of that group. Prior to July 1, 1986, airport firefighters were grouped with regular members and made the same contributions as regular members.

Notwithstanding the foregoing, all airport firefighter service prior to July 1, 2004, shall be coded by IPERS as sheriff/deputy sheriff/airport firefighter service, and all airport firefighter service after June 30, 2004, shall be coded by IPERS as protection occupation service. This coding, however, shall not supersede provisions of this title that require members to make contributions at higher rates in order to receive certain benefits, such as in the hybrid formula pursuant to 495—12.4(97B).

e. Airport safety officers employed under Iowa Code chapter 400 by an airport commission in a city with a population of 100,000 or more, and employees covered by the Iowa Code chapter 8A merit system whose primary duties are providing airport security and who carry or are licensed to carry firearms while performing those duties.

f. Effective July 1, 1990, an employee of the state department of transportation who is designated as a “peace officer” by resolution under Iowa Code section 321.477.

g. Effective July 1, 1992, a fire prevention inspector peace officer employed by the department of public safety. Effective July 1, 1994, a fire prevention inspector peace officer employed before that date who does not elect coverage under Iowa Code chapter 97A in lieu of IPERS.

h. Effective July 1, 1994, through June 30, 1998, a parole officer III with a judicial district department of correctional services.

i. Effective July 1, 1994, through June 30, 1998, a probation officer III with a judicial district department of correctional services.

j. Effective July 1, 2008, county jailers and detention officers working as jailers.

k. Effective July 1, 2008, National Guard installation security officers.

l. Effective July 1, 2008, emergency medical care providers.

m. Effective July 1, 2008, special investigators who are employed by county attorneys.

n. Effective July 1, 2014, an employee of the insurance division of the department of commerce who as a condition of employment is required to be certified by the Iowa law enforcement academy and who is required to perform the duties of a peace officer as provided in Iowa Code section 507E.8.

o. Effective July 1, 2014, an employee of a judicial district department of correctional services whose condition of employment requires the employee to be certified by the Iowa law enforcement academy and who is required to perform the duties of a parole officer as provided in Iowa Code section 906.2.

p. Effective July 1, 2016, a peace officer employed by an institution under the control of the state board of regents whose position requires law enforcement certification pursuant to Iowa Code section 262.13.

q. Effective July 1, 2016, a person employed by the department of human services as a psychiatric security specialist at a civil commitment unit for sexually violent offenders facility.

4.6(5) Service reclassification.

a. Prior to July 1, 2006, except as otherwise indicated in the implementing legislation or these rules, for a member whose prior regular service position is reclassified by the legislature as a special service position, all prior service by the member in such regular service position shall be coded by IPERS staff as special service if certified by the employer as constituting special service under current law. No additional contributions shall be required by regular service reclassified as special service under this paragraph.

b. Effective July 1, 2006, for a member whose prior regular service position is reclassified by the legislature as a special service position, all prior service by the member in such regular service position shall continue to be coded by IPERS staff as regular service unless the legislature specifically provides in its legislation for payment of the related actuarial costs of such reclassified service as required under Iowa Code section 97B.65.

4.6(6) Effective July 1, 2006, in the determination of a sheriff's or deputy sheriff's eligibility for benefits and the amount of such benefits under Iowa Code section 97B.49C, all protection occupation service credits for that member shall count toward the total years of eligible service as a sheriff or deputy sheriff. However, this subrule shall not be construed to alter the statutory requirement that a sheriff or deputy sheriff must be employed as a sheriff or deputy sheriff at termination of covered employment in order to qualify for benefits under Iowa Code section 97B.49C.

4.6(7) Pretax.

a. Effective January 1, 1995, employers must pay member contributions on a pretax basis for federal income tax purposes only. Such contributions are considered employer contributions for federal income tax purposes and employee contributions for all other purposes. Employers must reduce the member's salary reportable for federal income tax purposes by the amount of the member's contribution.

b. Salaries reportable for purposes other than federal income tax will not be reduced, including for IPERS, FICA, and, through December 31, 1998, state income tax purposes.

c. Effective January 1, 1999, employers must pay member contributions on a pretax basis for both federal and state income tax purposes.

[ARC 7591B, IAB 2/25/09, effective 7/1/09; ARC 7759B, IAB 5/6/09, effective 4/17/09; ARC 7916B, IAB 7/1/09, effective 8/5/09; ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 9397B, IAB 2/23/11, effective 3/30/11; ARC 0017C, IAB 2/22/12, effective 3/28/12; ARC 0662C, IAB 4/3/13, effective 5/8/13; ARC 1348C, IAB 2/19/14, effective 3/26/14; ARC 1887C, IAB 2/18/15, effective 3/25/15; ARC 2402C, IAB 2/17/16, effective 3/23/16; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 3684C, IAB 3/14/18, effective 4/18/18; ARC 4337C, IAB 3/13/19, effective 4/17/19; ARC 5027C, IAB 4/8/20, effective 5/13/20; ARC 5489C, IAB 3/10/21, effective 4/14/21]

495—4.7(97B) Employee information to be provided by covered employers. Covered employers are required to enroll new employees prior to reporting wages for the new employees using IPERS' employer self-service Internet application. Enrollment information shall include, but is not limited to, the following: member's name, social security number, date of birth, date of hire, occupation code, gender, mailing address, and employer identification number. When an employee terminates employment with a covered employer, the employer shall provide the termination date and the date of the employee's final paycheck.

[ARC 2981C, IAB 3/15/17, effective 4/19/17]

495—4.8(97B) Additional employer contributions from employer-mandated reduction in hours or by the exercise of bumping rights to avoid a layoff. Rescinded ARC 2981C, IAB 3/15/17, effective 4/19/17.

These rules are intended to implement Iowa Code sections 97B.4, 97B.9, 97B.14, 97B.14A, 97B.38, 97B.49A to 97B.49I, 97B.65 and 97B.70 and 2009 Iowa Acts, chapter 170, section 51, as amended by 2010 Iowa Acts, House File 2518, sections 36 and 41.

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[Filed ARC 5489C (Notice ARC 5359C, IAB 12/30/20), IAB 3/10/21, effective 4/14/21]

CHAPTER 5 EMPLOYEES

[Prior to 6/9/04, see 581—Ch 21]

495—5.1(97B) Identification of employees covered by the IPERS retirement law.

5.1(1) *Definition of employee—generally.* A person is in employment as defined by Iowa Code chapter 97B if the person and the covered employer enter into a relationship which both recognize to be that of employer/employee. An employee is an individual who is subject to control by the agency for whom the individual performs services for wages. The term “control” refers only to employment and includes control over the way the employee works, where the employee works and the hours the employee works. The control need not be actually exercised for an employer/employee relationship to exist; the right to exercise control is sufficient. A public official may be an “employee” as defined in the agreement between the state of Iowa and the Secretary of Health and Human Services, without the element of direction and control.

A person is not in employment if the person volunteers services to a covered employer for which the person receives no remuneration.

IPERS makes employment determinations based on a common law test, which factors in behavior control, financial control and relationship of the parties. Once this decision is made, if any party disagrees with the decision, the party in disagreement will be required to submit an SS-8 Determination of Workers Status form directly to the Internal Revenue Service (IRS). Upon receipt of the determination by the IRS, IPERS will review this hiring arrangement a second time. A Final Agency Determination will be made at that time.

Further, if a person is performing essential governmental functions that can only be performed by a governmental employee, that person shall be IPERS-covered.

5.1(2) *Optional coverage procedures—July 1, 1994, through December 31, 1998.* Effective July 1, 1994, a person who is employed in a position which allows IPERS coverage to be elected as specified in Iowa Code section 97B.1A(8) must file a one-time election form with IPERS for coverage. If the person was employed before July 1, 1994, the election must be postmarked on or before July 1, 1995. If the person was employed on or after July 1, 1994, the election must be postmarked within 60 days from the date the person was employed. Coverage will be prospective from the date the election is approved by IPERS. The election, once filed, is irrevocable and continues until the member terminates covered employment. The election window does not allow members who had been in coverage to elect out.

5.1(3) *Election out of Iowa Code chapter 97B coverage by certain protection occupation groups.* Effective July 1, 1994, members employed before that date as a gaming enforcement officer, a fire prevention inspector peace officer, or an employee of the division of capitol police (except clerical workers), may elect coverage under Iowa Code chapter 97A in lieu of IPERS. The election must be directed to the board of trustees established in Iowa Code section 97A.5 and postmarked on or before July 1, 1995.

5.1(4) *Optional coverage procedures—January 1, 1999.* Effective January 1, 1999, new hires who may elect out of IPERS coverage shall be covered on the date of hire and shall have 60 days to elect out of coverage in writing using IPERS’ forms. Notwithstanding the foregoing, employees who had the right to elect IPERS coverage prior to January 1, 1999, but did not do so, shall be covered as of January 1, 1999, and shall have until December 31, 1999, to elect out of coverage.

[ARC 3684C, IAB 3/14/18, effective 4/18/18]

495—5.2(97B) Coverage treatment for specific employee classifications. Employment as defined in Iowa Code chapter 97B is not synonymous with IPERS membership. Some classes of employees are explicitly excluded or membership is made optional under Iowa Code section 97B.1A(8) “b,” while other classes are excluded or membership is made optional by their nature. The following subrules are designed to clarify the status of certain employee positions.

5.2(1) Elected officials. Effective January 1, 1999, the following persons shall be covered by IPERS unless they elect out of coverage:

- a. Elected officials in positions for which the compensation is on a fee basis;

- b.* Elected officials of school districts;
- c.* Elected officials of townships; and
- d.* Elected officials of other political subdivisions who are in part-time positions.

An elected official who becomes covered under this chapter may later terminate membership by informing IPERS in writing of the expiration of the member's term of office or, if a member of the general assembly, of the intention to terminate coverage.

An elected official does not terminate covered employment with the end of each term of office if the official has been reelected for the same position. If elected for another position, the official shall be covered unless the official elects out of coverage.

5.2(2) County and municipal court bailiffs who receive compensation for duties shall be covered.

5.2(3) Full-time city attorneys shall be covered. Part-time city attorneys who are considered to be public officers or public employees shall be covered.

5.2(4) Magistrates shall be covered unless they elect out of IPERS coverage. Having made a choice to remain in IPERS coverage, a magistrate may not revoke that election and discontinue such coverage.

5.2(5) Office and clerical staff of a county medical examiner's office shall be covered. Effective January 1, 1995, county medical examiners and deputy county medical examiners who are full-time county employees shall be covered.

5.2(6) Police, firefighters, emergency personnel, and certain peace officers.

a. Effective July 1, 1994, police officers and firefighters of a city not participating in the retirement systems established under Iowa Code chapter 410 or 411 shall be covered.

b. Emergency personnel, such as ambulance drivers, who are deemed to be firefighters by the employer shall be covered as firefighters.

c. Effective January 1, 1995, part-time police officers shall be covered in the same manner as full-time police officers.

d. Reserve peace officers employed under Iowa Code chapter 80D shall not be covered in accordance with Iowa Code section 80D.14.

e. A police chief or fire chief who has submitted a written request to the board of trustees created by Iowa Code section 411.36 to be exempt from coverage under Iowa Code chapter 411 shall not be covered under IPERS in accordance with Iowa Code sections 384.6(1) and 411.3. The city shall make on behalf of such person the contributions required under Iowa Code section 384.6(1) to the International City Management Association/Retirement Corporation.

f. Peace officer candidates of the department of public safety shall not be covered.

g. An emergency medical care provider who provides emergency medical services, as defined in Iowa Code section 147A.1, and who is not a member of the retirement systems established in Iowa Code chapter 401 or 411 shall be covered.

5.2(7) County social welfare employees shall be covered.

5.2(8) Members of county soldiers relief commissions and their administrative or clerical employees shall be covered.

5.2(9) Part-time elected mayors, mayors of townships, and mayors who are paid on a fee basis are covered under IPERS unless they elect out of coverage. All other mayors, including appointed mayors and full-time elected mayors, whether elected by popular vote or by some other means, are covered.

5.2(10) Field assessors shall be covered.

5.2(11) Members of county boards of supervisors who receive an annual salary shall be covered. Effective for terms of office beginning January 1, 1999, part-time members of county boards of supervisors who receive an annual salary or are paid on a per diem basis shall be covered unless they elect out of coverage.

5.2(12) Temporary employees of the general assembly who are employed for less than six months in a calendar year or work less than 1,040 hours in a calendar year shall be covered unless the employee elects out of coverage. If coverage is elected, the member may not terminate coverage until termination of covered employment.

5.2(13) Effective July 1, 2008, temporary employees shall not be covered provided that they have not established an ongoing relationship with an IPERS-covered employer. An ongoing relationship with an IPERS-covered employer is established when:

a. The employee is paid covered wages of \$1,000 or more per quarter in two consecutive quarters; or

b. The employee is employed by a covered employer for 1,040 or more hours in a calendar year.

Coverage shall begin when the permanency of the relationship is established and shall continue until the employee's relationship with the covered employer is severed. If there is no formal severance, coverage for a person hired for temporary employment who has established an ongoing relationship with a covered employer shall continue until that person completes four consecutive calendar quarters in which no services are performed for that employer after the last covered calendar quarter.

No service credit will be granted to a temporary employee who has become a covered employee under this rule for any quarter in which no covered wages are reported unless the employee is on a leave of absence that qualifies for service credit under Iowa Code section 97B.1A(20). Contributions shall be paid, and service credit shall be accrued, when wages are paid in the quarter after the ongoing relationship has been established.

5.2(14) Drainage district employees who have vested rights to IPERS through earlier participation or employees of drainage districts shall be covered unless they elect out of coverage.

5.2(15) Full-time and part-time county attorneys shall be covered.

5.2(16) Tax study committee employees shall be covered.

5.2(17) School bus drivers who are considered to be public employees shall be covered. School bus drivers who are independent contractors shall not be covered. A determination must be made by IPERS on the facts presented on a case-by-case basis.

5.2(18) Full-time or part-time students employed part-time by the educational institution where they are enrolled shall not be IPERS-covered. Full-time and part-time student status is as defined by the individual educational institutions. Full-time and part-time employment status is as defined by the individual employers. If the employer is not the institution where the college student is enrolled, the college student is not exempt from IPERS coverage and employers would determine IPERS coverage by applying the usual permanent or temporary rules.

High school and lower grade students continue to be exempt from IPERS coverage.

5.2(19) Foreign exchange teachers and visitors including alien scholars, trainees, professors, teachers, research assistants and specialists in their fields of specialized knowledge or skill shall not be covered.

5.2(20) Members of any other retirement system in Iowa maintained in whole or in part by public funds shall not be covered. However, effective July 1, 1996, an employee who has two jobs, one covered by IPERS and one covered by another retirement system in Iowa, shall remain an IPERS-covered employee, unless the employee receives credit in such other retirement system for both jobs.

5.2(21) Members who are contributing to the federal civil service retirement system or federal employees retirement system shall not be covered. However, effective July 1, 1996, an employee who has two jobs, one covered by IPERS and one covered by a federal retirement system, shall be considered as an IPERS-covered employee, unless the employee receives credit in such federal retirement system for both jobs.

5.2(22) Employees of credit unions without capital stock organized and operated for mutual purposes without profit shall not be covered.

5.2(23) Members of the ministry, rabbinate or other religious order who perform full-time or part-time religious service for a covered employer shall be covered. However, members of the ministry, rabbinate or other religious order who have taken the vow of poverty may elect out of coverage.

5.2(24) Any physician, surgeon, dentist or member of other professional groups employed full-time by a covered employer shall be covered. However, any member of a professional group who performs part-time service for any public agency but whose private practice provides the major source of income shall not be covered, except for city attorneys and health officials.

5.2(25) Interns and resident doctors employed by a state or local hospital, school or institution shall not be covered.

5.2(26) Professional personnel who acquire the status of an officer of the state of Iowa or a political subdivision thereof, even though they engage in private practice and render government service only on a part-time basis, shall be covered.

5.2(27) Effective July 1, 1994, volunteer firefighters and special police officers are considered temporary employees and shall be covered if they meet the requirements of subrule 5.2(13).

5.2(28) Residents or inmates of county homes shall not be covered.

5.2(29) Members of the state transportation commission, the board of parole, and the state health facilities council shall be covered unless they elect out of coverage.

5.2(30) Employees of an interstate agency established under Iowa Code chapter 28E, and similar enabling legislation in an adjoining state, if the city had made contributions to the system for employees performing functions which are transferred to the interstate agency shall be considered employees of the city for the sole purpose of membership in IPERS, although the employer contributions for those employees are made by the interstate agency.

5.2(31) City managers, or city administrators performing the duties of city managers, under a form of city government listed in Iowa Code chapter 372 or 420 shall be covered unless they elect out of coverage.

5.2(32) Employees appointed by the state board of regents shall be covered unless they elect coverage in an alternative retirement system qualified by the state board of regents. An employee must make an election in the alternative retirement system within 60 days of the employee's first day of employment.

5.2(33) Employees who work in additional positions with additional duties, along with normal duties with the same employer, shall be considered covered employees until all of their compensated duties to their employer cease. (Examples include teacher/coach; teacher/summer driver's education instructor; and city employee/paid firefighter.)

5.2(34) Adjunct instructors employed by a community college or university shall not be covered. Adjunct instructors are persons employed by a community college or university without a continuing contract and whose teaching load does not exceed one-half time for two full semesters or three full quarters for the calendar year. The determination of whether a teaching load exceeds one-half time shall be based on the number of credit hours or noncredit contact hours that the community college or university considers to be a full-time teaching load for a regular full semester or quarter. An adjunct instructor whose teaching load exceeds the foregoing limitations shall be covered.

In determining whether an adjunct instructor is a covered employee, no credit shall be granted for teaching periods of shorter duration than a regular semester or regular quarter (such as summer semesters), regardless of the number of credit or contact hours assigned to that period.

If there is no formal severance, an adjunct instructor who becomes a covered employee shall remain a covered employee until that person completes four consecutive calendar quarters in which no services are performed for that covered employer after the last covered calendar quarter. Notwithstanding the foregoing sentence, no service credit will be granted to any adjunct instructor who has become a covered employee under this rule for any calendar quarter in which no covered wages are reported unless the adjunct instructor is on an approved leave of absence that qualifies for service credit under Iowa Code section 97B.1A(20).

5.2(35) Effective July 1, 1992, enrollees of a senior community service employment program authorized by Title V of the Older Americans Act and funded by the United States Department of Labor shall not be covered unless:

- a. Both the enrollee and the covered employer elect coverage; or
- b. The enrollee is currently contributing to IPERS.

For purposes of this subrule only, a covered employer is defined as the host agency where the enrollee is placed for training.

5.2(36) Employees of area agencies on aging shall be included. However, effective July 1, 1994, employees of area agencies on aging shall not be covered if the area agency has provided for

participation by all of its eligible employees in an alternative qualified plan pursuant to the requirements of the federal Internal Revenue Code. If an area agency on aging does not participate in an alternative plan, or terminates participation in such plan, IPERS coverage shall begin immediately.

5.2(37) Effective July 1, 1994, arson investigators shall not be covered. They were transferred to the public safety peace officers' retirement, accident and disability system as found in Iowa Code chapter 97A.

5.2(38) Persons who meet the requirements of independent contractor status as determined by IPERS using the criteria established by the federal Internal Revenue Service shall not be covered.

5.2(39) Effective July 1, 1994, a person employed on or after that date for certain public safety positions shall not be covered. These positions are gaming enforcement officers employed by the division of criminal investigation for excursion boat gambling enforcement activities, fire prevention inspector peace officers, and employees of the division of capitol police (except clerical workers).

5.2(40) Employees of area community colleges shall be covered unless they elect coverage under an alternative system pursuant to a one-time irrevocable election. An employee must make an election in the alternative retirement system within 60 days of the employee's first day of employment.

5.2(41) Volunteer emergency personnel, such as ambulance drivers and emergency medical technicians, shall be considered temporary employees and shall be covered if they meet the requirements of subrule 5.2(13). Persons who meet such requirements shall be covered under the protection occupation requirements of Iowa Code section 97B.49B if they are considered firefighters by their employers; otherwise they shall be covered under Iowa Code section 97B.1A.

5.2(42) Persons employed through any program described in Iowa Code section 84A.7 and provided by the Iowa conservation corps shall not be covered.

5.2(43) Appointed and full-time elective members of boards and commissions who receive a set salary shall be covered. Effective January 1, 1999, part-time elective members of boards and commissions not otherwise described in these rules who receive a set salary shall be covered unless they elect out of coverage. Members of boards, other than county boards of supervisors, and commissions, including appointed and elective full-time and part-time members, who receive only per diem and expenses shall not be covered.

5.2(44) Persons receiving rehabilitation services in a community rehabilitation program, rehabilitation center, sheltered workshop, and similar organizations whose primary purpose is to provide vocational rehabilitation services to target populations shall not be covered.

5.2(45) Persons who are members of a community service program authorized under and funded by grants made pursuant to the federal National and Community Service Act of 1990 shall not be covered.

5.2(46) Persons who are employed by professional employment organizations, temporary staffing agencies, and similar noncovered employers and are leased to covered employers shall not be covered.

5.2(47) Persons who are employed by a covered employer and leased to a noncovered employer shall be covered.

5.2(48) Effective July 1, 1999, persons performing referee services for a covered employer shall not be covered, unless the performance of such services is included in the persons' regular job duties for the employer for which such services are performed.

5.2(49) Effective July 1, 2000, patient advocates appointed under Iowa Code section 229.19 shall be covered.

5.2(50) Employees of the Iowa student loan liquidity corporation shall not be covered.

5.2(51) A citizen coach is an employee (permanent or temporary) who works for a school district in only a coaching capacity. An employer may provide a citizen coach with IPERS coverage immediately. If the employer chooses not to, then the following determination of IPERS coverage is needed:

a. If the citizen coach is expected to fill the position each season and cannot be unseated by another district employee, then the district and citizen coach have established a permanent relationship and IPERS coverage should begin once that citizen coach returns to coach a second season.

b. If there is no expectation of continued employment beyond the first season for the citizen coach, or if the citizen coach can be unseated by another district employee, then a temporary relationship exists and the citizen coach shall only be covered if the citizen coach meets the requirements of subrule 5.2(13). [ARC 0662C, IAB 4/3/13, effective 5/8/13; ARC 2402C, IAB 2/17/16, effective 3/23/16; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 3684C, IAB 3/14/18, effective 4/18/18; ARC 5489C, IAB 3/10/21, effective 4/14/21]

495—5.3(97B) Participation in IPERS and another retirement system. Effective July 1, 1996, an employee may actively participate in IPERS and another retirement system supported by public funds if the person does not receive credit under both IPERS and such other retirement system for the same position held.

[ARC 3684C, IAB 3/14/18, effective 4/18/18]

These rules are intended to implement Iowa Code sections 97B.1A, 97B.4, 97B.42, 97B.42A, 97B.49B, 97B.49C, and 97B.49G.

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CHAPTER 11
APPLICATION FOR, MODIFICATION OF, AND TERMINATION OF BENEFITS

[Prior to 11/24/04, see 581—Ch 21]

495—11.1(97B) Application for benefits.

11.1(1) Form used. It is the responsibility of the member to notify IPERS of the intention to retire. This should be done 60 days before the expected retirement date. The application for monthly retirement benefits is obtainable from IPERS, 7401 Register Drive, P.O. Box 9117, Des Moines, Iowa 50306-9117. The printed application form shall be completed by each member applying for benefits and shall be mailed, sent by fax or brought in person to IPERS. An application that is incomplete or incorrectly completed will be returned to the member. To be considered complete, an application must include the following:

- a. Proof of date of birth for the member.
- b. Option selected, and
 - (1) If Option 1 is selected, the death benefit amount.
 - (2) If Option 4 or 6 is selected, the contingent annuitant's name, social security number, proof of date of birth, and relationship to member. The member must designate the survivor benefit percentage, which shall be limited to one of the following:
 1. One hundred percent of the member's benefit amount.
 2. Seventy-five percent of the member's benefit amount.
 3. Fifty percent of the member's benefit amount.
 4. Twenty-five percent of the member's benefit amount.
 - (3) If Option 1, 2, or 5 is selected, a list of beneficiaries.
- c. If the member has been terminated less than one year, or is applying for disability benefits, the employer certification page must be completed by the employer unless the employer has provided the termination date and date of the last paycheck on the monthly wage reports.
- d. Signature of member and spouse.
- e. If the member has no spouse, "NONE" must be designated.
- f. If the member is applying for regular disability benefits, a copy of the award letter from the Social Security Administration or railroad retirement.
- g. An indication whether the member is a U.S. citizen, resident alien, or non-U.S. citizen.

A retirement application is deemed to be valid and binding on the date the first payment is paid. Members shall not cancel their applications, change their option choice, or change an IPERS option containing contingent annuitant benefits after that date.

11.1(2) Proof required in connection with application. Proof of date of birth to be submitted with an application for benefits shall be in the form of a birth certificate, a U.S. passport, an infant baptismal certificate, an identification card or driver's license issued by the state of Iowa, a state identification card that is issued in compliance with the REAL ID Act of 2005, or a driver's license that is issued in compliance with the REAL ID Act of 2005. If these records do not exist, the applicant shall submit two other documents or records which will verify the day, month and year of birth. A photographic identification record may be accepted even if now expired unless the passage of time has made it impossible to determine if the photographic identification record is that of the applicant. The following records or documents are among those deemed acceptable to IPERS as proof of date of birth:

- a. United States census record;
- b. Military record or identification card;
- c. Naturalization record;
- d. A marriage license showing age of applicant in years, months and days on date of issuance;
- e. A life insurance policy;
- f. Records in a school's administrative office;
- g. An official document from the U.S. Citizenship and Immigration Services, such as a "green card," containing such information;
- h. Driver's license or Iowa nondriver identification card;

- i.* Adoption papers; or
- j.* Any other document or record ten or more years old, or certification from the custodian of such records which verifies the day, month, and year of birth.

If the member, the member's representative, or the member's beneficiary is unable or unwilling to provide proof of birth, or in the case of death, proof of death, IPERS may rely on such resources as it has available, including but not limited to records from the Social Security Administration, Iowa division of records and statistics, IPERS' own internal records, or reports derived from other public records, and other departmental or governmental records to which IPERS may have access.

IPERS is required to begin making payments to a member or beneficiary who has reached the required beginning date specified by Internal Revenue Code Section 401(a)(9). In order to begin making such payments and to protect IPERS' status as a plan qualified under Internal Revenue Code Section 401(a), IPERS may rely on its internal records with regard to date of birth, if the member or beneficiary is unable or unwilling to provide the proofs required by this subrule within 30 days after written notification of IPERS' intent to begin mandatory payments.

11.1(3) *Benefits estimates.* Prior to submitting an application for benefits, a member may request IPERS to prepare estimates of projected benefits under the various options as described under Iowa Code section 97B.51. A benefit estimate shall not bind IPERS to payment of the projected benefits under the various options specified in Iowa Code chapter 97B. A member cannot rely on the benefit estimate in making any retirement-related decision or taking any action with respect to the member's account, nor shall IPERS assume any liability for such actions. An estimate will not include deductions for a QDRO or any other legal assignments or orders on a member's account, unless specifically requested by the member. A member's actual benefit can only be known and officially calculated when an eligible member applies for benefits.

11.1(4) *Revocation of application.* If IPERS determines an application for benefits is invalid for any reason, IPERS shall revoke, in whole or in pertinent part, the application for benefits and the recipient shall repay all payments made under the revoked application or all payments made pursuant to the revoked part of the application. The terms of repayment shall be subject to the provisions of 495—11.7(97B).

[ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 1348C, IAB 2/19/14, effective 3/26/14; ARC 1887C, IAB 2/18/15, effective 3/25/15; ARC 2402C, IAB 2/17/16, effective 3/23/16; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 5027C, IAB 4/8/20, effective 5/13/20; ARC 5489C, IAB 3/10/21, effective 4/14/21]

495—11.2(97B) Retirement benefits and the age reduction factor.

11.2(1) *Normal retirement.*

a. A member shall be eligible for monthly retirement benefits with no age reduction effective with the first of the month in which the member attains the age of 65, if otherwise eligible.

b. Effective July 1, 1998, a member shall be eligible for full monthly retirement benefits with no age reduction effective with the first of the month in which the member attains the age of 62, if the member has 20 full years of service and is otherwise eligible.

c. Effective July 1, 1997, a member shall be eligible to receive monthly retirement benefits with no age reduction effective the first of the month in which the member's age on the last birthday and the member's years of service equal or exceed 88, provided that the member is at least the age of 55 and is otherwise eligible.

11.2(2) *Early retirement.* A member shall be eligible to receive benefits for early retirement effective with the first of the month in which the member attains the age of 55 or the first of any month after attaining the age of 55 before the member's normal retirement date, provided the date is after the last day of service and the member is otherwise eligible.

11.2(3) *Aged 70 and older retirees.* A member shall be eligible to receive monthly retirement benefits with no age reduction effective with the first day of the month in which the member attains the age of 70, even if the member continues to be employed.

11.2(4) *Required beginning date.*

a. Notwithstanding the foregoing, IPERS shall commence payment of a member's retirement benefit under Iowa Code sections 97B.49A to 97B.49I (under Option 2) no later than the "required

beginning date” specified under Internal Revenue Code Section 401(a)(9), even if the member has not submitted the application for benefits. If the lump sum actuarial equivalent could have been elected by the member, payments shall be made in such a lump sum rather than as a monthly allowance. The “required beginning date” is defined as the later of: (1) April 1 of the year following the year that the member attains the age of 72 (or the age of 70 ½ for that member who attains the age of 70 ½ on or before December 31, 2019), or (2) April 1 of the year following the year that the member actually terminates all employment with employers covered under Iowa Code chapter 97B.

b. If IPERS distributes a member’s benefits without the member’s consent in order to begin benefits on or before the required beginning date, the member may elect to receive benefits under an option other than the default option described above, or as a refund, if the member contacts IPERS in writing within 60 days of the first mandatory distribution. IPERS shall inform the member which adjustments or repayments are required in order to make the change.

c. If a member cannot be located to commence payment on or before the required beginning date described above, the member’s benefit shall be forfeited. However, if a member later contacts IPERS and wishes to file an application for retirement benefits, the member’s benefits shall be reinstated.

d. For purposes of determining benefits, the life expectancy of a member, a member’s spouse, or a member’s beneficiary shall not be recalculated after benefits commence.

e. If an IPERS member has a qualified domestic relations order (QDRO) on file when a mandatory distribution is required, and the QDRO requires the member to choose a specific retirement option, IPERS shall pay benefits under the option required by the order.

11.2(5) *Mandatory distribution of small inactive accounts.* As soon as practicable after July 1, 2004, IPERS shall distribute small inactive accounts to members and beneficiaries as authorized in Iowa Code section 97B.48(5).

11.2(6) *Federal tax code limitation for selection of survivor percentages for same gender spouses.* Rescinded IAB 2/19/14, effective 3/26/14.

[ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 1348C, IAB 2/19/14, effective 3/26/14; ARC 1887C, IAB 2/18/15, effective 3/25/15; ARC 5027C, IAB 4/8/20, effective 5/13/20; ARC 5489C, IAB 3/10/21, effective 4/14/21]

495—11.3(97B) First month of entitlement (FME).

11.3(1) *General.* A member shall submit a written application to IPERS setting forth the retirement date, provided the member has attained at least age 55 by the retirement date and the retirement date is after the member’s last day of service. A member’s first month of entitlement shall be no earlier than the first day of the first month after the member’s date of termination from employment or, if later, the month provided for under subrule 11.3(2). No payment shall be made for any month prior to the month the completed application for benefits is received by IPERS.

If a member files a retirement application but fails to select a valid first month of entitlement, IPERS will select by default the earliest month possible. A member may appeal this default selection by sending written notice of the appeal postmarked on or before 30 days after a notice of the default selection was mailed to the member. Notice of the default selection is deemed sufficient if sent to the member at the member’s address.

11.3(2) *Additional FME provisions.* Effective January 1, 2001, employees of a school corporation who are permitted by the terms of their employment contracts to receive their annual salaries in monthly installments over periods ranging from 9 to 12 months may retire at the end of a school year and receive trailing wages through the end of the contract year if they have completely fulfilled their contract obligations at the time of retirement. For purposes of this paragraph, “school corporation” means body politic described in Iowa Code sections 260C.16 (community colleges), 273.2 (area education agencies) and 273.1 (K-12 public schools). For purposes of this paragraph, “trailing wages” means previously earned wage payments made to such employees of a school corporation after the first month of entitlement. This exception does not apply to hourly employees, including those who make arrangements with their employers to hold back hourly wages for payment at a later date, to employees who are placed on sick or disability leave or leave of absence, or to employees who receive lump sum leave, vacation leave, early retirement incentive pay or any other lump sum payments in installments.

For all employees of all IPERS-covered employers who terminate employment in January 2003, or later, if the final paycheck is paid within the same quarter or within one quarter after termination and wages are reported under the normal pay schedule, the first month of entitlement shall be the month following termination. However, if the last paycheck is paid more than one quarter after the termination, the first month of entitlement shall be the first month after the employee is paid the last paycheck. Under no circumstances shall such trailing wages result in more than one quarter of service credit being added to retiring members' earning records.

11.3(3) *Survival into designated FME.* To be eligible for a monthly retirement benefit, the member must survive into the designated first month of entitlement. If the member dies prior to the first month of entitlement, the member's application for monthly benefits is canceled and the distribution of the member's account is made pursuant to Iowa Code section 97B.52. Cancellation of the application shall not invalidate a beneficiary designation. If the application is dated later in time than any other designations, IPERS will accept the designation in a canceled application as binding until a subsequent designation is filed.

11.3(4) *Members retiring under the rule of 88.* The first month of entitlement of a member qualifying under the rule of 88 shall be the first of the month when the member's age as of the last birthday and years of service equal 88. The fact that a member's birthday allowing a member to qualify for the rule of 88 is the same month as the first month of entitlement does not affect the retirement date.

[ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—11.4(97B) Termination of monthly retirement allowance. A member's retirement benefit shall terminate after payment is made to the member for the entire month during which the member's death occurs. Death benefits shall begin with the month following the month in which the member's death occurs.

Upon the death of the retired member, IPERS will reconcile the decedent's account to determine if an overpayment was made to the retired member and if further payment(s) is due to the retired member's named beneficiary, contingent annuitant, heirs at law or estate. If an overpayment has been made to the retired member, IPERS will determine if steps should be taken to seek collection of the overpayment from the named beneficiary, contingent annuitant, estate, heirs at law, or other interested parties.

495—11.5(97B) Bona fide retirement and bona fide refund.

11.5(1) *Bona fide retirement—general.* To receive retirement benefits, a member under the age of 70 must officially leave employment with all IPERS-covered employers, give up all rights as an employee, and complete a period of bona fide retirement. A period of bona fide retirement means four or more consecutive calendar months for which the member qualifies for monthly retirement benefit payments. The qualification period begins with the member's first month of entitlement for retirement benefits as approved by IPERS. A member may not return to covered employment before filing a completed application for benefits. Notwithstanding the foregoing, the continuation of group insurance coverage at employee rates for the remainder of the school year for a school employee who retires following completion of services by that individual shall not cause that person to be in violation of IPERS' bona fide retirement requirements.

A member will not be considered to have a bona fide retirement if the member is a school or university employee and returns to work with the employer after the normal summer vacation. In other positions, temporary or seasonal interruption of service which does not terminate the period of employment does not constitute a bona fide retirement. A member also will not be considered to have a bona fide retirement if the member has, prior to or during the member's first month of entitlement, entered into verbal or written arrangements with the member's former employer(s) to return to employment after the expiration of the four-month bona fide retirement period.

Effective July 1, 1990, a school employee will not be considered terminated if, while performing the normal duties, the employee performs for the same employer additional duties which take the employee beyond the expected termination date for the normal duties. Only when all the employee's compensated duties cease for that employer will that employee be considered terminated.

The bona fide retirement period shall be waived for an elected official covered under Iowa Code section 97B.1A(8)“a”(1), and for a member of the general assembly covered under Iowa Code section 97B.1A(8)“a”(2), when the elected official or legislator notifies IPERS of the intent to terminate IPERS coverage for the elective office and, at the same time, terminates all other IPERS-covered employment prior to the issuance of the retirement benefit. Such an elected official or legislator may remain in the elective office and receive an IPERS retirement without violating IPERS’ bona fide retirement rules. If such elected official or legislator terminates coverage for the elective office and also terminates all other IPERS-covered employment but is then reemployed in covered employment, and has not received a retirement as of the date of hire, the retirement shall not be made. Furthermore, if such elected official or legislator is reemployed in covered employment, the election to revoke IPERS coverage for the elective position shall remain in effect, and the elected official or legislator shall not be eligible for new IPERS coverage for such elected position. The prior election to revoke IPERS coverage for the elected position shall also remain in effect if such elected official or legislator is reelected to the same position without an intervening term out of office.

The bona fide retirement period will be waived if the member has been elected to public office which term begins during the normal four-month bona fide retirement period. This includes elected officials who shall be covered under this chapter as defined in Iowa Code section 97B.1A. This waiver does not apply if the member was an elected official who was reelected to the same position for another term.

Effective July 1, 2000, a member does not have a bona fide retirement until all employment with covered employers, including employment which is not covered under this chapter, is terminated for at least one month, and the member does not return to covered employment for an additional three months. In order to receive retirement benefits, the member must file a completed application for benefits before returning to any employment with a covered employer.

Effective July 1, 2018, a member will not have a bona fide retirement if the member enters into a verbal or written arrangement to perform duties for the member’s former employer(s) as an independent contractor prior to or during the member’s first month of entitlement or performs any duties for the member’s former employer(s) as an independent contractor prior to receiving four months of retirement benefits.

11.5(2) Bona fide refund. For a member to be eligible for a lump sum refund, the member must terminate the member’s covered employment and incur a bona fide separation from service and remain out of employment for at least 30 days with all covered employers. The 30-day bona fide refund period shall be waived for an elected official covered under Iowa Code section 97B.1A(8)“a”(1), and for a member of the general assembly covered under Iowa Code section 97B.1A(8)“a”(2), when the elected official or legislator notifies IPERS of the intent to terminate IPERS coverage for the elective office and, at the same time, terminates all other IPERS-covered employment prior to the issuance of the refund. Such an official may remain in the elective office and receive an IPERS refund without violating IPERS’ bona fide refund rules. If such elected official terminates coverage for the elective office and also terminates all other IPERS-covered employment but is then reemployed in covered employment, and has not received a refund as of the date of hire, the refund shall not be made. Furthermore, if such elected official is reemployed in covered employment, the election to revoke IPERS coverage for the elective position shall remain in effect, and the public official shall not be eligible for new IPERS coverage for such elected position.

The prior election to revoke IPERS coverage for the elected position shall also remain in effect if such elected official is reelected to the same position without an intervening term out of office. The waiver granted in this subrule shall be applicable to such elected officials who were in violation of the prior bona fide refund rules on and after November 1, 2002, when such individuals have not repaid the previously invalid refund.

If a member takes a refund in violation of the bona fide refund requirements of Iowa Code section 97B.53(4), the member may return the refund during the bona fide retirement period and restore the member’s account. If the repayment is not made, the member shall receive no credit for the period covered by the refund. At retirement, the member may purchase, at actuarial cost, the service credit covered by the refund.

11.5(3) *Part-time appointed members of boards or commissions receiving minimal noncovered wages.* Solely for purposes of determining whether a member has severed all employment with all covered employers and has remained out of employment as required under Iowa Code section 97B.52A, persons who have been appointed as part-time members of boards or commissions prior to or during their first month of entitlement and who receive only per diem and reimbursements for reasonable business expenses for such positions will be deemed not to be in employment prohibited under Iowa Code section 97B.52A.

For purposes of this subrule, per diem shall not exceed the amount authorized under Iowa Code section 7E.6(1) “a” for members of boards, committees, commissions, and councils within the executive branch of state government. This limit shall apply regardless of whether or not the position in question is within the executive branch of state government.

Members of boards and commissions not exempted under this subrule include: (a) those who are entitled to the payment of per diem regardless of attendance at board or commission meetings, and (b) those who would have received per diem in excess of the amount authorized under Iowa Code section 7E.6(1) “a” were it not for an agreement by the member to waive such compensation.

Persons appointed as part-time board or commission members who receive only per diem as set forth above and reimbursements of reasonable business expenses may continue in or accept appointments to such positions without violating the bona fide retirement rules under Iowa Code section 97B.52A.

11.5(4) *Members of the national guard who are called into state active duty.* Effective May 25, 2008, members of the national guard who are called into state active duty as defined in Iowa Code section 29A.1 in noncovered positions during the required period of complete severance will not be in violation of the bona fide retirement requirements of Iowa Code section 97B.52A as amended by 2010 Iowa Acts, House File 2518, section 33.

[ARC 8929B, IAB 7/14/10, effective 6/21/10; ARC 9068B, IAB 9/8/10, effective 10/13/10; ARC 0662C, IAB 4/3/13, effective 5/8/13; ARC 3684C, IAB 3/14/18, effective 4/18/18; ARC 4100C, IAB 10/24/18, effective 11/28/18; ARC 4337C, IAB 3/13/19, effective 4/17/19; ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—11.6(97B) Payment processing and administration.

11.6(1) *Monthly paper warrants processing fee.* Effective July 1, 2005, IPERS shall charge a per-warrant processing fee to members who choose to receive paper warrants in lieu of electronic deposits of their monthly retirement allowance. The fee may be waived if the person establishes that it would be an undue hardship for the person to do what is necessary to receive payment of the person’s IPERS monthly retirement allowance by electronic deposit. The processing fee will be deducted from the member’s retirement allowance on a posttax basis.

For purposes of this subrule, a member claiming undue hardship must establish that the cost normally assessed for the processing of paper warrants would be unduly burdensome because of the member’s limited income, or is otherwise financially burdensome or physically impracticable.

11.6(2) *Repeated requests for replacement warrants.* Effective July 1, 2002, for a member or beneficiary who, due to the member’s or beneficiary’s own actions or inactions, has benefits warrants replaced twice in a six-month period, except when the need for a replacement warrant is caused by IPERS’ failure to mail to the address specified by the recipient, payment shall be suspended until such time as the recipient establishes a direct deposit account in a bank, credit union or similar financial institution and provides IPERS with the information necessary to make electronic transfer of said monthly payments. Persons subject to said cases may be required to provide a face-to-face interview and additional documentation to prove that such a suspension would result in an undue hardship.

11.6(3) *Forgery claims.* When a forgery of a warrant issued in payment of an IPERS refund or benefit is alleged, the claimant must complete and sign an affidavit before a notary public that the endorsement is a forgery. A supplementary statement must be attached to the affidavit setting forth the details and circumstances of the alleged forgery.

11.6(4) *Rollover fees.* Effective January 1, 2007, if the recipient of a lump-sum distribution which qualifies to be rolled over requests that a rollover be made to more than one IRA or other qualified plan, IPERS may assess a \$5 administrative fee for each additional rollover beyond the first one. The fee will be deducted from the gross amount of each distribution, less federal and state income tax.

11.6(5) *Offsets against amounts payable.* IPERS may, with or without consent and upon reasonable proof thereof, offset amounts currently payable to a member or the member's designated beneficiaries, heirs, assigns or other successors in interest by the amount of IPERS benefits paid in error to or on behalf of such member or the member's designated beneficiaries, heirs, assigns or other successors in interest.

11.6(6) *Lump sum paper warrants processing fee.* Effective April 1, 2012, and thereafter, IPERS shall charge \$1 for paper warrants issued in payment of all nonrecurring lump sum distributions. If a nonrecurring lump sum distribution is followed by a supplemental lump sum distribution due to the reporting of additional covered wages, the \$1 processing fee shall also be charged. This \$1 processing fee shall not apply to a direct rollover described under Iowa Code section 97B.53B (however, processing fees may be charged for multiple rollover requests), lump sum mandatory account distributions required under Iowa Code section 97B.48(5), mandatory lump sum distributions required under Internal Revenue Code Section 401(9), or warrants reissued in forged endorsement or other fraudulent payment situations. [ARC 0017C, IAB 2/22/12, effective 3/28/12]

495—11.7(97B) Overpayment of IPERS benefits.

11.7(1) *Overpayments—general.*

a. An “overpayment” means a payment of money by IPERS that results in a recipient receiving a higher payment than the recipient is entitled to under the provisions of Iowa Code chapter 97B.

b. A “recipient” is a person or beneficiary, heir, assign, or other successor in interest who receives an overpayment from an IPERS benefit and is liable to repay the amount(s) upon receipt of a written explanation and request for the amounts to be repaid.

c. If IPERS determines that the cost of recovering the amount of an overpayment is estimated to exceed the overpayment, the repayment may be deemed to be unrecoverable.

d. If the overpayment is equal to or less than \$50 and cannot be recovered from other IPERS payments, IPERS may limit its recovery efforts to written requests for repayment and other nonjudicial remedies.

11.7(2) *Overpayment made to a retired member.* A retired member shall receive written notice of overpayment, including the reason for the overpayment, the amount of the overpayment, and a limited opportunity to repay the overpayment in full without interest. If a retired member repays an overpayment in full within 30 days after the date of the notice, there will be no interest charge. A retired member may repay an overpayment out of pocket or direct IPERS to recover the overpayment from future retirement benefit payments, or a combination of both. If the retired member cannot repay an overpayment in full, either out of pocket or from the next monthly installment of retirement benefits, or both, interest shall be charged. A retired member who cannot repay the full amount of the overpayment within 30 days after the date of the notice must enter into an agreement with IPERS to make monthly installment payments, or to have the overpayment offset against future monthly benefit payments or death benefits, if any, and authorize any unpaid balance as a first priority claim in the recipient's estate.

11.7(3) *Overpayment made to a person other than a retired member.* A recipient other than a retired member, except a recipient listed in subrule 11.5(2), shall receive written notice of overpayment, including the reason for the overpayment, the amount of the overpayment, and the opportunity to repay the overpayment in full without interest. If such a recipient repays an overpayment in full within 30 days after the date of the notice, there will be no interest charge. If such a recipient cannot repay an overpayment in full within 30 days after the date of the notice, interest shall be charged. If repayment in full cannot be made within 30 days, such a recipient shall make repayment arrangements subject to IPERS' approval within 30 days of the written notice and request for repayment.

If the overpayment recipient cannot be located to receive notice of the overpayment at the recipient's last-known address, IPERS shall, after trying to locate the person, consider the recipient to have waived entitlement to the quarters covered by the refund.

11.7(4) *Interest charges.*

a. *Overpayment not fraudulent.* If the overpayment of benefits, other than an overpayment that results from a violation described in subrule 11.5(2), was not the result of wrongdoing, negligence, misrepresentation, or omission of the recipient, the recipient is liable to pay interest charges at the rate

of 5 percent, or the rate IPERS determines, on the outstanding balance, beginning 30 days after the date of notice of the overpayment(s) is provided by IPERS.

b. Overpayments in violation of Iowa Code section 97B.40 or 715A.8. If the overpayment of benefits, other than an overpayment that results from a violation described in subrule 11.5(2), was the result of wrongdoing, negligence, misrepresentation, or omission of the recipient, the recipient is liable to pay interest charges at the rate of 7 percent on the outstanding balance, beginning on the date of the overpayment(s).

c. Overpayments that result in a judgment. In addition to other remedies, IPERS may file a civil action to recover overpayments, and the interest rate may be set by the court.

11.7(5) Recovery of overpayment from a deceased recipient. If a recipient dies prior to the full repayment of an erroneous overpayment of benefits, IPERS shall be entitled to apply to the estate of the deceased to recover the remaining balance.

11.7(6) Offsets against amounts payable. IPERS may, in addition to other remedies and after notice to the recipient, request an offset against amounts owing to the recipient by the state according to the offset procedures pursuant to Iowa Code sections 8A.504 and 421.17.

11.7(7) Rights of appeal. A recipient who is notified of an overpayment and required to make repayments under this rule may appeal IPERS' determination in writing to the CEO or CEO's designee. The written request must explain the basis of the appeal and must be received by IPERS' office within 30 days of overpayment notice pursuant to 495—Chapter 26.

11.7(8) Release of overpayment. IPERS may release a recipient from liability to repay an overpayment, in whole or in part, if IPERS determines that the receipt of overpayment is not the fault of the recipient, and that it would be contrary to equity and good conscience to collect the overpayment. No release of an individual recipient's obligation to repay an overpayment shall stand as precedent for release of another recipient's obligation to repay an overpayment.

[ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 1887C, IAB 2/18/15, effective 3/25/15; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 3684C, IAB 3/14/18, effective 4/18/18; ARC 5027C, IAB 4/8/20, effective 5/13/20]

These rules are intended to implement Iowa Code sections 97B.4, 97B.9A, 97B.15, 97B.25, 97B.38, 97B.40, 97B.45, 97B.47, 97B.48, 97B.48A, 97B.49A to 97B.49I, 97B.50, 97B.51, 97B.52, 97B.52A, 97B.53, and 97B.53B.

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CHAPTER 12
CALCULATION OF MONTHLY RETIREMENT BENEFITS

[Prior to 11/24/04, see 581—Ch 21]

495—12.1(97B) General.

12.1(1) *Formula benefit versus money purchase benefit.* If a member is vested by years of service credit in IPERS, a monthly payment allowance will be paid in accordance with the formulas set forth in Iowa Code sections 97B.49A through 97B.49I, the applicable paragraphs of this chapter, and the option the member elects pursuant to Iowa Code section 97B.51(1). IPERS shall determine on the applicable forms which designated fractions of a member's monthly retirement allowance payable to contingent annuitants shall be provided as options under Iowa Code section 97B.51(1). Any option elected by a member under Iowa Code section 97B.51(1) must comply with the requirements of the Internal Revenue Code that apply to governmental pension plans, including but not limited to Internal Revenue Code Section 401(a)(9). If a member is not vested by years of service credit in IPERS, the benefit receivable will be computed on a money purchase basis, with reference to annuity tables used by IPERS in accordance with the member's age and option choice.

12.1(2) *Reduction for early retirement for regular class members.*

a. Effective July 1, 1988, through December 31, 2000, a member's benefit formula will be reduced by .25 percent for each month the member's retirement precedes the normal retirement date, as defined in Iowa Code section 97B.45 excluding section 97B.45(4). The following are situations in which a member is considered to be taking early retirement:

(1) If a member has not attained the age of 65 in the member's first month of entitlement and has less than 20 years of service; or

(2) If a member has not attained the age of 62 in the month of the member's retirement and has 20 years of service.

b. Effective July 1, 1997, a member shall be eligible to receive monthly retirement benefits with no age reduction effective the first of the month in which the member's age on the last birthday and the member's years of service equal or exceed 88, provided that the member is at least the age of 55.

c. Effective July 1, 1991, a member qualifying for early retirement due to disability under Iowa Code section 97B.50 shall not be subject to a reduction in benefits due to age.

d. If a member retires with at least 20 years of service but has not attained the age of 62, the age reduction shall be calculated by deducting .25 percent per month for each month that the first month of entitlement precedes the month in which the member attains the age of 62. If a member retires with less than 20 years of service, the age reduction shall be calculated by deducting .25 percent per month for each month that the first month of entitlement precedes the month in which the member attains the age of 65.

e. Effective January 1, 2001, the age reduction shall be calculated by deducting .25 percent per month for each month that the first month of entitlement precedes the earliest possible normal retirement date for that member based on the age and years of service at the member's actual retirement.

f. For the portion of the member's retirement allowance based on service through June 30, 2012, the early retirement reduction shall be calculated as provided in paragraphs 12.1(2)"a" through "e." For the portion of the retirement allowance based on years of service beginning July 1, 2012, and later, the member's early retirement reduction shall be one-half of one percent for each month that the early retirement precedes the date the member attains age 65.

12.1(3) *Early retirement date for regular class members.* A member's early retirement date shall be the first day of the month of the fifty-fifth birthday or any following month before the normal retirement date, provided that date is after the member's termination date.

12.1(4) *Benefit formulas for members retiring on or after July 1, 2012.*

a. For each member retiring on or after July 1, 2012, who is vested by service, the monthly benefit will be equal to one-twelfth of an amount equal to 60 percent of the final average covered wage multiplied by a fraction of years of service.

b. For all active and inactive vested members, the monthly retirement allowance shall be determined on the basis of the formula in effect on the date of the member's retirement. If the member takes early retirement, the benefit shall be adjusted as provided in subrule 12.1(2).

c. In addition to the 60 percent multiplier identified above, regular class members who retire with years of service in excess of 30 years shall have the percentage multiplier increased by .25 percent for each quarter of a year in excess of 30, not to exceed an increase of 5 percent.

d. In addition to the 60 percent multiplier identified above, protection occupation members, sheriffs, and deputy sheriffs who retire with years of service in excess of 22 years shall have the percentage multiplier increased by .375 percent for each quarter of a year in excess of 22, not to exceed an increase of 12 percent.

e. Regular service does not count as "eligible service" in determining a special service member's applicable percentage.

12.1(5) *Average covered wages for special service members and for wages of regular class members prior to July 2012.*

a. "Three-year average covered wage" means a member's covered calendar year wages averaged for the highest three years of the member's service. However, for the member's final year of wages, IPERS may determine the wages for the third year by computing the final quarter or quarters of wages to complete the year. The computed year will be created when the final quarter or quarters reported are combined with a computed average quarter to complete the last year. The value of this average quarter will be computed by selecting the highest covered wage year not used in the computation of the three high years and dividing the covered salary by four quarters. This value will be combined with the final quarter or quarters to complete a full calendar year. If the member's final quarter of wages will reduce the three-year average covered wage, it can be dropped from the computation. However, if the covered wages for that quarter are dropped, the service credit for that quarter will be forfeited as well. If the final quarter is the first quarter of a calendar year, those wages must be used in order to give the member a computed year. The computed year wages shall not exceed the Internal Revenue Service maximum covered wage in effect for that calendar year. Furthermore, the computed year shall not exceed the member's highest actual calendar year of covered wages by more than 3 percent. Effective July 1, 2007, a member's high three-year average wage shall be the greater of (1) the member's high three-year average covered wage based on covered wages reported through June 30, 2007; or (2) the member's high three-year average covered wage after application of the antispiking control as described in paragraph 12.1(5) "b" below.

b. Antispiking limit on the growth of a member's high three-year average.

(1) Selection of the control year shall give highest priority to calendar years of wages in which there are four quarters of service credit for wages on file not used in the high three-year average wage calculation. For example, if the member receives \$20,000 of wages for a calendar year with four quarters of service credit for wages, and the member also has received \$30,000 of wages for a calendar year with three quarters of service credit for wages, the control year selection process shall give preference to the calendar year with \$20,000 of reported wages.

(2) If there is a calendar year of covered wages outside the high three-year average wage calculation that has four quarters, but the covered wages for that year are less than the covered wages for the fourth highest calendar year of covered wages, and that fourth highest calendar year of covered wages does not have four quarters of service credit for wages, the control year will be the lowest of the high three calendar years of wages with service credits for wages in all four quarters being used in the high three-year average wage calculation.

(3) "Service credit for wages" means service credit recorded for:

1. Quarters in which the member receives covered wages from covered employment.
2. Quarters in which the member is credited with covered wages due to a military leave.
3. Quarters in which the member would have had covered wages but for the application of the IRS covered wage limitations.
4. Quarters in which an employee of a nine-month institution receives service credit for a qualifying leave of absence under 495—subrule 7.1(2).

5. Quarters in which a legislator, legislative employee, or elected official receives service credit for employment.

(4) If none of the calendar years of wages that fall outside of the high three-year average wage calculation have service credit for wages reported in all four quarters, the control year will then be the lowest of the high three calendar years of wages with service credit for wages in all four quarters being used in the high three-year average wage calculation.

(5) If none of the wage years used in the high three-year average wage calculation have service credits for wages reported in all four quarters, the control year will then revert to the highest calendar year of wages not included in the high three-year average wage calculation, regardless of whether there are fewer than four quarters with service credits for wages on file.

(6) For high three-year average wage calculations that utilize the computed year, the control year may be the calendar year from which the “average quarters” used in the computed year are drawn. However, the control year cannot be the computed year, as the computed year will never be a calendar year with service credit for wages in all four quarters.

c. Effective July 1, 2012, a nonvested regular class member’s average covered wage shall be the member’s five-year average covered wage calculated as provided in Iowa Code section 97B.1A(10A) “a.”

d. Effective July 1, 2012, for regular class members vested as of June 30, 2012, the member’s average covered wage shall be the greater of the member’s three-year average covered wage calculated as provided under paragraphs 12.1(5) “a” and “b,” or the member’s five-year average covered wage calculated as provided in Iowa Code section 97B.1A(10A) “a.” The “five-year average covered wage” means a member’s covered calendar year wages averaged for the highest five years of the member’s service. However, in the member’s final year of wages, IPERS may determine the wages for the fifth year by computing the final quarter or quarters of wages to complete the year. The computed year wages shall not exceed the Internal Revenue Service maximum covered wage in effect for that calendar year. Furthermore, the computed year shall not exceed the member’s highest actual calendar year of covered wages by more than 3 percent. A full fifth year will be created when the final quarter or quarters reported are combined with a computed average quarter to complete the last year. The value of this average quarter will be computed by selecting the highest covered wage year not used in the computation of the five high years and dividing the covered salary by four quarters. This value will be combined with the final quarter or quarters of wages to complete a full calendar year. If the member’s final quarter of wages will reduce the five-year average covered wage, it can be dropped from the computation. However, if the covered wages for that quarter are dropped, the service credit for that quarter will be forfeited as well. If the final quarter is the first quarter of a calendar year, those wages must be used in order to give the member a computed year. The five-year average covered wage cannot exceed the highest Internal Revenue Service maximum covered wages in effect during the member’s service. In addition, the average five-year salary is restricted to an antispiking limit of 134 percent of the highest sixth year of wages.

[ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 0017C, IAB 2/22/12, effective 3/28/12; ARC 1348C, IAB 2/19/14, effective 3/26/14; ARC 1887C, IAB 2/18/15, effective 3/25/15; ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—12.2(97B) Initial benefit determination.

12.2(1) The initial monthly benefit for the retired member will be calculated utilizing the wages that have been reported as of the member’s retirement and subject to the requirements of subrule 12.1(5). When the final quarter(s) of wages is reported for the retired member, a recalculation of benefits will be performed by IPERS to redetermine the member’s benefit amount. In cases where the recalculation determines that the benefit will be changed, the adjustment in benefits will be made retroactive to the first month of entitlement. The wages for the “computed year” shall not exceed the highest covered wage ceiling in effect during the member’s period of employment.

12.2(2) In cases where the member’s final quarter’s wages have been reported to IPERS prior to retirement, the original benefit will be calculated utilizing all available wages.

12.2(3) The Option 1 death benefit amount cannot exceed the member’s investment and cannot lower the member’s benefit below the minimum distribution required by federal law.

[ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—12.3(97B) Hybrid formula for members with more than one type of service credit.

12.3(1) Eligibility. Effective July 1, 1996, members having both regular and special service (as defined in Iowa Code section 97B.1A(22)) shall receive the greater of the benefit amount calculated under this subrule or the benefit amount calculated under the applicable nonhybrid benefit formula.

a. Members who are vested by service as defined in Iowa Code section 97B.1A(25) “*d*” may utilize the hybrid formula.

b. The following classes of members are not eligible for the hybrid formula:

- (1) Members who have only regular service credit.
- (2) Members who have 22 years of special service credit.
- (3) Members who have 30 years of regular service.
- (4) Members who are not vested by service as defined in Iowa Code section 97B.1A(25) “*d*.”

12.3(2) Assumptions. IPERS shall utilize the following assumptions in calculating benefits under this rule.

a. The member’s average covered wage shall be determined in the same manner as it is determined for the nonhybrid formula.

b. Increases in the benefit formula under this rule shall be determined as provided under Iowa Code section 97B.49D. The percentage multiplier shall only be increased for total years of service over 30.

c. Years of service shall be utilized as follows:

(1) Quarters which have two or more occupation class codes shall be credited as the class that has the highest reported wage for said quarter. A member shall not receive more than one quarter of credit for any calendar quarter, even though more than one type of service credit is recorded for that quarter.

(2) Quarters shall not be treated as special service quarters unless the applicable employer and employee contributions have been made.

12.3(3) Years of service fraction not to exceed one.

a. In no event shall a member’s years of service fraction under the hybrid formula exceed, in the aggregate, one.

b. If the years of service fraction does, in the aggregate, exceed one, the member’s quarters of service credit shall be reduced until the member’s years of service fraction equals, in the aggregate, one.

c. Service credit shall first be subtracted from the member’s regular service credit and, if necessary, shall next be subtracted from the member’s special service credit.

12.3(4) Age reduction. The portion of the member’s benefit calculated under this rule that is based on the member’s regular service shall be subject to a reduction for early retirement. In calculating the age reduction to be applied to the portion of the member’s benefit based on the member’s regular service, the system shall use all quarters of service credit, including both regular and special service quarters.

12.3(5) Calculations. A member’s benefit under the hybrid formula shall be the sum of the following:

a. The applicable percentage multiplier divided by 22 times the years of special service credit times the member’s high three-year average covered wage, plus

b. The applicable percentage multiplier divided by 30 times the years of regular service credit (if any) times the member’s high three-year average prior to July 1, 2012, or the member’s high five-year average after June 30, 2012, covered wage minus the applicable wage reduction (if any).

c. If the sum of the percentages obtained exceeds the applicable percentage multiplier for that member, the percentage obtained above for each class of service shall be subject to reduction so that the total shall not exceed the member’s applicable percentage multiplier in the order specified in paragraph 12.3(3) “*c*.”

[ARC 0017C, IAB 2/22/12, effective 3/28/12; ARC 4337C, IAB 3/13/19, effective 4/17/19; ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—12.4(97B) Money purchase benefits.

12.4(1) For each member not vested by service as defined in Iowa Code section 97B.1A(25) “*d*,” a monthly annuity shall be determined by applying the total member and employer’s accumulated

contributions as of the effective retirement date to the annuity tables in use by the system according to the member's age (or member's and contingent annuitant's ages, if applicable).

12.4(2) For each vested member for whom the present value of future benefits under Option 2 is less than the member reserve as of the effective retirement date, a monthly annuity shall be determined by applying the member reserve to the annuity tables in use by the system according to the member's age (or member's and contingent annuitant's ages, if applicable).

12.4(3) For calculations under subrule 12.4(1), Options 2, 3, 4, 5 and 6 shall be calculated by dividing the member's total reserve by the applicable Option 2, 3, 4, 5 or 6 annuity factor taken from the system's tables to determine the monthly amount. For calculations under subrule 12.4(2), Options 2, 3, 4, 5 and 6 shall be calculated by dividing the member reserve by the applicable Option 2, 3, 4, 5 or 6 annuity factor taken from the system's tables to determine the monthly amount.

12.4(4) For Option 1, the cost per \$1,000 of death benefit shall be determined according to the system's tables. That cost shall be subtracted from the Option 3 monthly amount to determine the Option 1 monthly benefit amount. The Option 1 death benefit amount shall be reduced as necessary so that the Option 1 monthly benefit amount is not less than one-half of the Option 2 monthly benefit amount.

12.4(5) For members retiring after June 30, 2012, the money purchase benefit calculated pursuant to this rule shall be provided to members who are not vested by service as defined in Iowa Code section 97B.1A(25) "d."

[ARC 0017C, IAB 2/22/12, effective 3/28/12; ARC 0662C, IAB 4/3/13, effective 5/8/13; ARC 4337C, IAB 3/13/19, effective 4/17/19; ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—12.5(97B) Recalculation for a member aged 70. A member remaining in covered employment after attaining the age of 70 years may receive a retirement allowance without terminating the covered employment. A member who is in covered employment, attains the age of 70 and begins receiving a retirement allowance must terminate all covered employment before the member's retirement allowance can be recalculated to take into account service after the member's original FME. The termination of employment must be a true severance lasting at least 30 days. The formula to be used in recalculating such a member's retirement allowance depends on the date of the member's FME and the member's termination date, as follows:

If the member is receiving a retirement allowance with an FME prior to July 1, 2000, and terminates covered employment on or after January 1, 2000, the member's retirement formula for recalculation purposes shall be the formula in effect at the time of the member's termination from covered employment or, if later, the date the member applies for a recalculation.

In all other cases, the recalculation for a member aged 70 who retires while actively employed shall use the retirement formula in effect at the time of the member's FME.

Payments under this rule shall begin no earlier than the month following the month of termination, upon IPERS' receipt of a member's application for recalculation. It is the member's responsibility to apply for the recalculation by completing and submitting the form specified by IPERS.

A member receiving a recalculation under this rule after June 30, 2012, will have the member's average covered wage calculated as follows. IPERS will calculate the average high three covered wage as of June 30, 2012. IPERS will next calculate the average high five covered wage at the time of the member's termination from covered employment or, if later, the date the member applies for a recalculation. IPERS will determine the benefit amount based on the calculation that produces the greatest benefit to the member.

[ARC 0662C, IAB 4/3/13, effective 5/8/13; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—12.6(97B) Level payment choice for special service members. A level payment choice is created effective July 1, 2002. IPERS shall implement the level payment choice by preparing factors to convert nonhybrid IPERS Options 1, 2, 3, 4, and 5 to the level payment choice. The new benefit feature applies solely to special service members, and any reference to members in this rule shall only apply to special service members.

12.6(1) Member's social security retirement amount. Calculations of a member's level payment choice shall be based on the member's social security retirement amount at age 62 as verified by

Social Security Administration statements provided by the member. No adjustments shall be made if subsequent social security statements indicate an increase in the age 62 social security retirement amount. Verification of the social security benefits shall not precede the member's first month of entitlement by more than 12 months.

12.6(2) *Death benefit assumptions.* In preparing level payment choice factors, IPERS shall assume:

a. For IPERS Options 1 and 2, death benefits under those options shall not be reduced as a result of a member's attaining the age of 62 and having the member's monthly allowance reduced under this rule.

b. For IPERS Options 4 and 5, IPERS shall assume that the contingent annuitant's or beneficiary's monthly payments and death benefits, if any, prior to the date the member attains, or would have attained, age 62 shall be based on the amount that was payable to the member for periods before the member attains, or would have attained, age 62. Beginning with the month after the month that the member attains, or would have attained, age 62, a contingent annuitant's or beneficiary's monthly payments and death benefits, except death benefits under IPERS Options 1 and 2, shall be based on the reduced amount that would have been payable to the member in the month after the month that the member attained age 62.

12.6(3) *Favorable experience dividends.* An eligible member's or beneficiary's favorable experience dividend, if any, shall be based on the member's or beneficiary's level payment choice monthly amount as of the preceding December 31.

12.6(4) *Prohibitions.* The following special service members shall be prohibited from receiving benefits under this rule:

a. Those who retire under Iowa Code section 97B.49D, 97B.50(2), or 97B.50A.

b. Those who retire under Option 6.

c. Those who request a level payment amount that reflects less than a full offset for the social security retirement amount at age 62.

d. Those reemployed in covered employment and subsequently retiring, for the period of reemployment. A member who has elected the level payment choice shall have retirement benefits calculated solely for the period of reemployment, except for vesting credit.

12.6(5) *Limit on reductions.* The level payment choice factors shall not reduce the monthly amount payable to a member at age 62 to less than 50 percent of the monthly amount that would have been payable under IPERS Option 2. Accordingly, payments before age 62 to such members shall be reduced in the same manner, with the corresponding adjustments made to death benefits.

12.6(6) *Commencement of level payment option reduction.* The monthly benefit of a member who selects the level payment option shall be reduced beginning with the month after the member reaches age 62.

[ARC 0017C, IAB 2/22/12, effective 3/28/12; ARC 1887C, IAB 2/18/15, effective 3/25/15; ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—12.7(97B) Reemployment of retired members.

12.7(1) Effective July 1, 1998, the monthly benefit payments for a member under the age of 65 who has a bona fide retirement and is then reemployed in covered employment shall be reduced by 50 cents for each dollar the member earns in excess of the annual limit. Effective July 1, 2002, this reduction is not required until the member earns the amount of remuneration permitted for a calendar year for a person under the age of 65 before a reduction in federal social security retirement benefits is required, or earns \$30,000, whichever is greater. The foregoing reduction shall apply only to IPERS benefits payable for the applicable year that the member has reemployment earnings and after the earnings limit has been reached. Said reductions shall be applied as provided in subrule 12.7(2).

Effective January 1, 1991, this earnings limitation does not apply to covered employment as an elected official. A member aged 65 or older who has completed at least four full calendar months of bona fide retirement and is later reemployed in covered employment shall not be subject to any wage-earning disqualification.

12.7(2) Beginning on or after July 1, 1996, the retirement allowance of a member subject to reduction pursuant to subrule 12.7(1) shall be reduced as follows:

a. A member's monthly retirement allowance in the following calendar year shall be reduced by the excess benefit paid in the preceding year after the excess benefit payment amount has been determined.

b. Employers shall be required to complete IPERS wage reporting forms for reemployed individuals which shall reflect the prior year's wage payments on a month-to-month basis. These reports shall be used by IPERS to determine the amount which must be recovered to offset overpayments in the prior calendar year due to reemployment wages.

c. The member's overpayment shall be collected as follows:

(1) IPERS will reduce the member's gross monthly benefit by 50 percent until the overpayment is repaid. If the 50 percent reduction will not recover the overpayment by the end of the current calendar year, IPERS will calculate the monthly reduction amount so that the overpayment will be recovered within the current calendar year. Other monthly reduction amounts may be made by an agreement in writing between the member and IPERS; or

(2) A member may elect to make repayments of the overpayment amounts out of pocket in lieu of having the member's monthly benefit reduced. An out-of-pocket repayment may be made in one check or in installments. However, an election to make repayment in installments must be agreed to in writing between the member and IPERS.

(3) If a member dies and the full amount of overpayment determined under this subrule has not been repaid, the remaining amounts shall be deducted from the payments to be made, if any, to the member's designated beneficiary or contingent annuitant. If the member has selected an option under which there are no remaining amounts to be paid, or the remaining amounts are insufficient, the unrecovered amounts shall be a charge on the member's estate.

(4) A member may elect in writing to have the member's monthly retirement allowance suspended in the month in which the member's remuneration exceeds the amount of remuneration permitted under this subrule in lieu of receiving a reduced retirement allowance under subparagraph (1). In order to become effective, the member's written election must be delivered to IPERS in person, by regular mail, email, facsimile or by private carrier. Oral elections shall not be accepted. The member's election to suspend benefit payments in the month when the member's remuneration exceeds the amount of reimbursement permitted under this subrule shall remain in effect for all subsequent calendar years until revoked by the member in writing. If the member's written election is not received in time to avoid overpayment, the overpayment must be recovered, to the extent possible, from monthly amounts beginning in January of the next calendar year or under one of the alternate arrangements permitted under this rule. Effective July 1, 2007, remuneration shall include those amounts as described in 495—subrule 6.3(13).

12.7(3) A member who is reemployed in covered employment after retirement may, after again retiring from employment, request a recomputation of benefits. The member's retirement benefit shall be increased if possible by the addition of a second annuity, which is based on years of reemployment service, reemployment covered wages and the benefit formula in place at the time of the recomputation. A maximum of 30 years of service is creditable to an individual retired member. If a member's combined years of service exceed 30, a member's initial annuity may be reduced by a fraction of the years in excess of 30 divided by 30. The second retirement benefit will be treated as a separate annuity by IPERS.

Effective July 1, 1998, a member who is reemployed in covered employment after retirement may, after again terminating employment for at least one full calendar month, elect to receive a refund of the employee and employer contributions made during the period of reemployment in lieu of a second annuity. If a member requests a refund in lieu of a second annuity, the related service credit shall be forfeited.

Effective July 1, 2007, employer contributions described in 495—subrule 6.3(13) shall constitute "remuneration" for purposes of applying the reemployment earnings limit and determining reductions in the member's monthly benefits but shall not be considered covered wages for IPERS benefits calculations.

It is the member's responsibility to apply for the recomputation or lump sum by completing and submitting the form specified by IPERS.

12.7(4) In recomputing a retired member's monthly benefit, IPERS shall use the following assumptions.

- a.* The member cannot change the option or beneficiary with respect to the reemployment period.
- b.* If the member would only qualify for a money purchase benefit under rule 495—12.4(97B) based solely on the period of reemployment, then the money purchase formula shall be used to compute the additional benefit amount due to the reemployment.
- c.* If the member would qualify for a non-money purchase retirement allowance based solely on the period of reemployment, the benefit formula in effect as of the first month of entitlement (FME) for the reemployment period shall be used. If the FME is July 1998 or later, and the member has more than 30 years of service, including both original and reemployment service, the percentage multiplier for the reemployment period only will be at the applicable percentage (up to 65 percent) for the total years of service.
- d.* If a period of reemployment would increase the monthly benefit a member is entitled to receive, the member may elect between the increase and a refund of the employee and employer contributions without regard to reemployment FME.
- e.* If a member previously elected IPERS Option 1, is eligible for an increase in the Option 1 monthly benefits, and elects to receive the increase in the member's monthly benefits, the member's Option 1 death benefit shall also be increased if the investment is at least \$1,000. The amount of the increase shall be at least the same percentage of the maximum death benefit permitted with respect to the reemployment as the percentage of the maximum death benefit elected at the member's original retirement. In determining the increase in Option 1 death benefits, IPERS shall round up to the nearest \$1,000. For example, if a member's investment for a period of reemployment is \$1,900 and the member elected at the member's original retirement to receive 50 percent of the Option 1 maximum death benefit, the death benefit attributable to the reemployment shall be \$1,000 (50 percent times \$1,900, rounded up to the nearest \$1,000). Notwithstanding the foregoing, if the member's investment for the period of reemployment is less than \$1,000, the benefit formula for a member who originally elected new IPERS Option 1 shall be calculated under IPERS Option 3.
- f.* A retired reemployed member who requests a return of the employee and employer contributions made during a period of reemployment cannot repay the distribution and have the service credit for the period of reemployment restored.
- g.* If a retired reemployed member selected IPERS Option 5 at retirement, and after the period of reemployment requests an increase in the member's monthly allowance, at death all remaining guaranteed payments with respect to both periods of employment shall be paid in a commuted lump sum.
- h.* If a retired reemployed member selected IPERS Option 2 at retirement, and after the period of reemployment requests an increase in the member's monthly allowance, at death the member's monthly payments following the increase shall be prorated between the member's two annuities to determine the amount of the member's remaining accumulated contributions that may be paid as a death benefit.
- i.* A retired reemployed member who has attained the age of 70 may take an actuarial equivalent (AE) payment. However, such a member must terminate covered employment for at least 30 days before taking an additional AE payment.

12.7(5) Mandatory distribution of active wages. If a retired reemployed member whose annual benefit would be increased by less than \$600 does not request a second annuity or a lump sum payment of reemployment accruals by the end of the fourth quarter after the last quarter in which the member had covered wages, IPERS shall proceed to pay the member the applicable lump sum amount. The member shall have 60 days after the postmark date of the mandatory payment to return the payment and request a benefit increase.

[ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 0017C, IAB 2/22/12, effective 3/28/12; ARC 1887C, IAB 2/18/15, effective 3/25/15; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 5027C, IAB 4/8/20, effective 5/13/20; ARC 5489C, IAB 3/10/21, effective 4/14/21]

495—12.8(97B) Actuarial equivalent (AE) payments.

12.8(1) If a member aged 55 or older requests an estimate of benefits which results in a monthly benefit amount under Option 2 of less than \$50, the member shall receive, under Iowa Code section 97B.48(1), a lump sum actuarial equivalent (AE) payment in lieu of a monthly benefit. Once the AE payment has been paid to the member, the member shall not be entitled to any further benefits based on the contributions included in the AE payment and the employment period represented thereby. If the member later returns to covered employment, any future benefits the member accrues shall be based solely on the new employment period. If an estimate of benefits based on the new employment period again results in any one of the options having a monthly benefit amount of less than \$50, the member may again elect to receive an AE payment.

12.8(2) If a member, upon attaining the age of 70 or later, requests a retirement allowance without terminating employment and the member's monthly benefit amount under Option 2 is less than \$50, the member shall receive an AE payment based on the member's employment up to, but not including, the quarter in which the application is filed. When the member subsequently terminates covered employment, any benefits due to the member will be based only on the period of employment not used in computing the AE paid when the member first applied for a retirement allowance. If an estimate of benefits based on the later period of employment again results in a monthly benefit amount under Option 2 of less than \$50, the member shall receive another AE payment. However, a member who elects to receive an AE payment upon or after attaining age 70 without terminating employment may not elect to receive additional AE payments unless the member terminates all covered employment for at least one full calendar month.

12.8(3) An AE payment under this rule shall be equal to the sum of the member's and employer's accumulated contributions.

[ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—12.9(97B) Conforming rules for lump sum payments. Effective January 1, 2007, IPERS may, notwithstanding certain provisions of Iowa Code section 97B.53B enacted in order to comply with prior rollover provisions of the Internal Revenue Code, utilize forms and procedures affording payees of lump sum distributions with broader rollover rights as permitted under the applicable rollover provisions of the Internal Revenue Code as amended subsequent to the enactment of Iowa Code section 97B.53B.

[ARC 5027C, IAB 4/8/20, effective 5/13/20]

These rules are intended to implement Iowa Code sections 97B.1A, 97B.1A(24), 97B.15, 97B.25, 97B.45, 97B.47 to 97B.48A, 97B.49A to 97B.49I, 97B.51, and 97B.53B.

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CHAPTER 13
DISABILITY FOR REGULAR AND SPECIAL SERVICE MEMBERS

[Prior to 11/24/04, see 581—Ch 21]

495—13.1(97B) Disability for persons retiring under Iowa Code section 97B.50(2).

13.1(1) For IPERS members retiring because of a disability:

a. The member must be awarded federal social security benefits due to a disability which existed on or before the member's first month of entitlement.

b. Effective July 1, 1990, the member may also qualify for the IPERS disability provision by being awarded, and commencing to receive, disability benefits through the federal Railroad Retirement Act, 45 U.S.C. Section 231 et seq., due to a disability which existed at the time of retirement.

c. The period for which up to 36 months of retroactive payments under Iowa Code section 97B.50(2) shall be paid is for up to 36 months preceding the month in which such completed application for IPERS disability is received by IPERS. In no event shall retroactive disability benefits payments under Iowa Code section 97B.50(2) precede the month the member actually receives the member's first social security or railroad retirement disability payment. The member shall provide IPERS with a copy of the Social Security Administration or railroad retirement award letter showing dates of eligibility.

d. Continued qualification monitoring.

(1) For a member retiring due to a disability under Iowa Code section 97B.50(2), on or after July 1, 2009, the member shall provide IPERS with proof of continuing eligibility for federal social security disability benefits or railroad retirement disability benefits by June 30 of each calendar year, in order to continue qualification for IPERS disability benefits.

IPERS shall suspend the disability benefits of any member if the records required are not timely provided.

(2) The annual certification of continued eligibility for federal social security disability benefits or railroad retirement disability benefits is not required as of the calendar year the member reaches normal retirement age as defined by Iowa Code section 97B.45, or for special service members aged 55, or sheriffs and deputies aged 50 with 22 years of service.

13.1(2) If a member returns to covered employment after achieving a bona fide retirement, the benefits being provided to the member under Iowa Code section 97B.50(2) "a" or "b" shall be suspended or reduced as follows. If the member has not attained the age of 55 upon reemployment, benefit payments shall be suspended in their entirety until the member subsequently terminates employment, applies for, and is approved to receive benefits under the provisions of Iowa Code chapter 97B. If the member has attained the age of 55 or older upon reemployment, the member shall continue to receive monthly benefits adjusted as follows. Monthly benefits shall be calculated under the same benefit option that was first selected, based on the member's age, years of service, and the applicable reductions for early retirement as of the month that the member returns to covered employment. The suspension or reduction of benefits for returning to covered employment no longer applies as of the calendar year the member reaches normal retirement age, as defined by Iowa Code section 97B.45, or for special service members aged 55, or sheriffs and deputies aged 50 with 22 years of service. The member's benefit shall also be subject to the applicable provisions of Iowa Code section 97B.48A pertaining to reemployed retired members.

13.1(3) Upon terminating a reemployment that resulted in the suspension of all or a portion of the member's disability retirement allowance, the member's benefits shall be recomputed under Iowa Code section 97B.48A and rule 495—12.8(97B). To requalify for a monthly retirement allowance under Iowa Code section 97B.50(2), the member must furnish a new or updated Social Security Administration disability award letter, or other acceptable documentation from the Social Security Administration, indicating that the member is currently eligible for social security disability benefits.

13.1(4) If a member whose IPERS disability benefits were suspended because of the member's return to covered employment provides proof acceptable to IPERS that the member remains eligible for federal social security disability benefits or railroad retirement disability benefits, IPERS shall reinstate the member's disability benefits, subject to the member's continued compliance with paragraph 13.1(1) "d."

[ARC 1348C, IAB 2/19/14, effective 3/26/14; ARC 1887C, IAB 2/18/15, effective 3/25/15; ARC 5027C, IAB 4/8/20, effective 5/13/20; ARC 5489C, IAB 3/10/21, effective 4/14/21]

495—13.2(97B) Disability claim process for special service members. Except as otherwise indicated, this rule shall apply only to disability claims initiated under Iowa Code section 97B.50A. Except as otherwise indicated, disability claims under Iowa Code section 97B.50(2) shall be administered under rule 495—13.1(97B).

13.2(1) *Initiation of disability claim.* The disability claim process shall originate as an application to the system by the member. The application shall be forwarded to the system's designated retirement benefits officer. An application shall be sent upon request to members who qualify pursuant to Iowa Code section 97B.50A(13). The application consists of the following sections which must be completed and returned to the system's designated retirement benefits officer:

1. General applicant information.
2. Applicant's statement.
3. Employer's statement.
4. Member's assigned duties.
5. Disability/injury reports.
6. Medical information release.

13.2(2) *Preliminary processing.* Completed forms shall be returned to the disability retirement benefits officer. If the forms are not complete, they will be returned for completion. The application package shall contain copies of all relevant medical records and the names, addresses, and telephone numbers of all relevant physicians. If medical records are not included, the designated retirement benefits officer shall have the authority to contact the listed physicians for copies of the files on the individual and shall request that any applicable files be sent to the medical board. In addition, IPERS may request workers' compensation records, social security records and such other official records as are deemed necessary. The application, including copies of the medical information, shall be forwarded to the medical board for review. All medical records that will be part of a member's permanent file shall be kept in locked locations separate from the member's other retirement records.

13.2(3) *Scheduling of appointments.* Upon receipt and forwarding of the application and sufficient medical records to the medical board, the disability retirement benefits officer shall establish an appointment for the applicant to be seen by the medical board in Iowa City. The member shall be notified in writing of the appointment and shall be given general instructions about where to go for the examinations. The appointment for the examinations shall be no later than 60 days after the completed application, including sufficient medical records, is provided. The member shall also be notified about the procedures to follow for reimbursement of travel expenses and lodging. Fees for physical examinations and medical records costs shall be paid directly by IPERS pursuant to its contractual arrangements with the medical providers required to implement Iowa Code section 97B.50A.

13.2(4) *Medical board examinations.* The medical board, consisting of three physicians from the University of Iowa occupational medicine clinic and other departments as required, shall examine the member and perform the relevant tests and examinations.

The medical board shall submit a letter of recommendation to the system, based on its findings and the job duties supplied in the member's application, whether or not the member is mentally or physically incapacitated from the further performance of the member's duties and whether or not the incapacity is likely to be permanent. "Permanent" means that the mental or physical incapacity is reasonably expected to last more than one year. The medical board's letter of recommendation shall include a recommended schedule for reexaminations to determine the continued existence of the disability in question.

IPERS shall not be liable for any diagnostic testing procedures performed in accordance with Iowa Code section 97B.50A and this rule which are alleged to have resulted in injury to the members being examined.

The medical board shall furnish its determination, test results, and supporting notes to the system no later than ten working days after the date of the examination. The medical board may use electronic signatures in fulfilling its reporting obligations under this rule.

The medical board shall not be required to have regular meetings, but shall be required to meet with IPERS' representatives at reasonable intervals to discuss the implementation of the program and performance review.

13.2(5) Member and employer comments. Upon receipt by the system, the medical board's determination regarding the existence or nonexistence of a permanent disability shall be distributed to the member and to the employer for review. The member and the employer may forward to the system written statements pertaining to the medical board's findings within ten days of transmittal. If relevant medical information not considered in materials previously forwarded to the medical board is contained within such written statements, the system shall submit such information to the medical board for review and comment.

13.2(6) Fast-track review. IPERS' disability retirement benefits officer may refer any case to IPERS' chief benefits officer (CBO) for fast-track review. The CBO or the CBO's designee may, based upon a review of the member's application and medical records, determine that the medical board be permitted to make its recommendations based solely upon a review of the application and medical records, without requiring the member to submit to additional medical examinations by, or coordinated through, the medical board.

13.2(7) Initial administrative determination. The medical board's letter of recommendation, test results, and supporting notes, and the member's file shall be forwarded to IPERS. Except as otherwise requested by IPERS, the medical board shall forward hospital discharge summary reports rather than the entire set of hospital records. The complete file shall be reviewed by the system's disability retirement benefits officer, who shall, in consultation with the system's legal counsel, make the initial disability determination. Written notification of the initial disability determination shall be sent to the member and the member's employer within 14 business days after a complete file has been returned to IPERS for the initial disability determination.

13.2(8) General benefits provisions. Effective July 1, 2000, if an initial disability determination is favorable, benefits shall begin as of the date of the initial disability determination or, if earlier, the member's last day on the payroll, but no more than six months of retroactive benefits are payable, subject to Iowa Code section 97B.50A(13). "Last day on the payroll" shall include any form of authorized leave time, whether paid or unpaid. If a member receives short-term disability benefits from the employer while awaiting a disability determination hereunder, disability benefits will accrue from the date the member's short-term disability payments are discontinued. If an initial favorable determination is appealed, the member shall continue to receive payments pending the outcome of the appeal.

Any member who is awarded disability benefits under Iowa Code section 97B.50A and this rule shall be eligible to elect any of the benefit options available under Iowa Code section 97B.51. All such options shall be the actuarial equivalent of the lifetime monthly benefit provided in Iowa Code section 97B.50A(2) and (3).

The disability benefits established under this subrule shall be eligible for the favorable experience dividends payable under Iowa Code section 97B.49F(2).

If the award of disability benefits is overturned upon appeal, the member may be required to repay the amount already received or, upon retirement, have payments suspended or reduced until the appropriate amount is recovered.

13.2(9) In-service disability determinations. Subject to the presumptions contained in Iowa Code section 97B.50A in determining whether a member's mental or physical incapacity arises in the actual performance of duty, "duty" shall mean:

a. For special service members other than firefighters, any action that the member, in the member's capacity as a law enforcement officer:

(1) Is obligated or authorized by rule, regulation, condition of employment or service, or law to perform; or

(2) Performs in the course of controlling or reducing crime or enforcing the criminal law; or

b. For firefighters, any action that the member, in the member's capacity as a firefighter:

(1) Is obligated or authorized by rule, regulation, condition of employment or service, or law to perform; or

(2) Performs while on the scene of an emergency run (including false alarms) or on the way to or from the scene.

c. A presumption shall exist that a special service member contracted a disease while on active duty only if the disease is defined by Iowa Code section 97B.50A(2) “c” as amended by 2010 Iowa Acts, House File 2518, section 31. If a presumption exists, IPERS may, in making its determination as to whether a disability was incurred while the member was on active duty, go forward with evidence to rebut the presumption. IPERS can rebut the presumption when credible evidence exists to the contrary or when the requirements are met in Iowa Code section 97B.50A(2) “c” as amended by 2010 Iowa Acts, House File 2518, section 31. Under no circumstances shall the burden of proof shift from the special service member to IPERS.

13.2(10) Appeal rights. The member or the employer, or both, may appeal IPERS’ initial disability determination. Within 30 days after the notification of IPERS’ initial disability determination was mailed, the member shall submit to IPERS’ CEO or CEO’s designee a notice of appeal in writing setting forth:

a. The name, address, and social security number of the member or employee number of the employer;

b. A reference to the decision from which the appeal is being made;

c. The fact that an appeal from the decision is being made;

d. The grounds upon which the appeal is based;

e. Additional medical or other evidence to support the appeal; and

f. The request that a different decision be made by IPERS.

The system shall conduct an internal review of the initial disability determination, and the CEO or CEO’s designee shall notify in writing the party who filed the appeal of IPERS’ final disability determination with respect to the appeal. The CEO or CEO’s designee may appoint a review committee to make nonbinding recommendations on such appeals. The disability retirement benefits officer, if named to the review committee, shall not vote on any such recommendations, nor shall any members of IPERS’ legal staff participate in any capacity other than a nonvoting capacity. Further appeals shall follow the procedures set forth in 495—Chapter 26.

13.2(11) Notice of abuse of disability benefits. The system has the obligation and full authority to investigate allegations of abuse of disability benefits. The scope of the investigation to be conducted shall be determined by the system, and may include the ordering of a sub rosa investigation of a disability recipient to verify the facts relating to an alleged abuse. A sub rosa investigation shall only be considered upon receipt and evaluation of an acceptable notice of abuse. The notification must be in writing and include:

a. The informant’s name, address, telephone number, and relationship to the disability recipient; and

b. A statement pertaining to the circumstances that prompted the notification, such as activities which the informant believes are inconsistent with the alleged disability.

c. Anonymous calls shall not constitute acceptable notification.

IPERS may employ such investigators and other personnel, in IPERS’ sole discretion, as may be deemed necessary. IPERS may also, in its sole discretion, decline to carry out such investigations if more than five years have elapsed since the date of the disability determination.

13.2(12) Qualification for social security or railroad retirement disability benefits. Upon qualifying for social security or railroad retirement disability benefits, a special service member may contact the system to have the member’s disability benefits calculated under Iowa Code section 97B.50(2). The member and spouse must complete the designated application to stop having benefits calculated under Iowa Code section 97B.50A and to start having benefits calculated under Iowa Code section 97B.50(2). The decision is irrevocable, and must be made within 60 days after the member receives written notification of eligibility for disability benefits from social security or railroad retirement and has commenced receiving such payments.

13.2(13) Reemployment/income monitoring. A member who retires under Iowa Code section 97B.50A and this rule shall be required to supply a copy of a complete set of the member’s state and federal income tax returns, including all supporting schedules, by June 30 of each calendar year, in order to continue qualification for IPERS special service disability benefits. IPERS may suspend the

benefits of any such member if such records are not timely provided. This subrule does not apply to a member who is at least 55 years of age and would have completed 22 years of service if the member had remained in active special service employment.

Only wages and self-employment income shall be counted in determining a member's reemployment comparison amount, as adjusted for health care coverage for the member and member's dependents.

13.2(14) Offset to allowance. A member who retires under Iowa Code section 97B.50A shall have benefits reduced by other disability-related payments the member receives for the same disability, including, but not limited to benefits from:

- a. Social security.
- b. Long-term disability insurance.
- c. Workers' compensation.
- d. Unemployment insurance.
- e. Employer-paid disability plans, programs, or policies.
- f. Other laws.

For purposes of calculating the income offsets required under Iowa Code section 97B.50A, IPERS shall convert any lump sum workers' compensation award, disability insurance payments, or similar lump sum awards for the same illnesses or injuries to an actuarial equivalent, as determined by IPERS. IPERS shall convert any monthly, weekly, or other stated period workers' compensation award, disability insurance payments, or other awards for the same illnesses or injuries, dollar-for-dollar, to the same monthly, weekly, or other stated period, as determined by IPERS.

[ARC 8929B, IAB 7/14/10, effective 6/21/10; ARC 9068B, IAB 9/8/10, effective 10/13/10; ARC 0662C, IAB 4/3/13, effective 5/8/13; ARC 2402C, IAB 2/17/16, effective 3/23/16; ARC 5027C, IAB 4/8/20, effective 5/13/20]

These rules are intended to implement Iowa Code sections 97B.50 and 97B.50A.

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CHAPTER 14
DEATH BENEFITS AND BENEFICIARIES

[Prior to 11/24/04, see 581—Ch 21]

495—14.1(97B) Internal Revenue Code limitations. The death benefits payable under Iowa Code sections 97B.51 and 97B.52 shall not exceed the maximum amount possible under Internal Revenue Code Section 401(a)(9).

To ensure that the limit is not exceeded, a member's combined lump sum death benefit under Iowa Code sections 97B.52(1) and 97B.52(2) shall not exceed 100 times the Option 2 amount that would have been payable to the member at the member's earliest normal retirement age. If a beneficiary of a special service member is eligible for an in-the-line-of-duty death benefit, any reduction required under this rule shall be taken first from a death benefit payable under Iowa Code section 97B.52(1). The "100 times" limit shall apply to active and inactive members. The death benefits payable under this chapter for a period of reemployment for a retired reemployed member who dies during the period of reemployment shall also be subject to the limits described in this rule.

The maximum claims period for IPERS lump sum death benefits shall not exceed the period required under Internal Revenue Code Section 401(a)(9), which may be less than five years for a member who dies after the member's required beginning date, unless the beneficiary is a spouse. The claims period for all cases in which the member's death occurs during the same calendar year in which a claim must be filed under this rule shall end April 1 of the year following the year of the member's death.

A member's beneficiary or heir may file a claim for previously forfeited death benefits. Interest, if any, for periods prior to the date of the claim will only be credited through the quarter that the death benefit was required to be forfeited by law. Interest for periods following the quarter of forfeiture will accrue beginning with the quarter that the claim for reinstatement is received by IPERS. For death benefits required to be forfeited in order to satisfy Section 401(a)(9) of the federal Internal Revenue Code, in no event will the forfeiture date precede January 1, 1988. IPERS shall not be liable for any excise taxes imposed by the Internal Revenue Service on reinstated death benefits.

Effective January 14, 2004, all claims for a previously forfeited death benefit shall be processed under the procedure set forth at rule 495—14.6(97B).

The system recognizes the validity of same gender marriages executed in Iowa on or after April 27, 2009, if the domestic relations order or other assignment otherwise meets the system's minimum requirements for such orders; the system shall modify the tax treatment of distributions under such orders as required by the federal laws governing such distributions. IPERS shall adopt such rules and procedures as are deemed necessary to fully implement the provisions of this rule. The Iowa Supreme Court decision recognizing same gender marriages in Iowa specifically states that this recognition does not extend to same gender marriages of other states. The system recognizes the validity of same gender marriages based on the U.S. Supreme Court's decision in *United States v. Windsor*, 133 S.Ct. 2675 (2013) and the direction of Rev. Rul. 2013-17 and IRS Notice 2014-19. IPERS shall recognize the federal tax treatment of distributions as required by the sources listed in this paragraph.

[ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 1348C, IAB 2/19/14, effective 3/26/14; ARC 1887C, IAB 2/18/15, effective 3/25/15; ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—14.2(97B) Survival into first month of entitlement. When a member who has filed an application for retirement benefits and has survived into the first month of entitlement dies prior to the issuance of the first benefit check, IPERS will pay the death benefit allowed under the retirement option elected by the member in the application for retirement benefits.

495—14.3(97B) Designation of beneficiaries.

14.3(1) Designation of beneficiaries. To designate a beneficiary, the member must complete an IPERS designation of beneficiary form, which must be filed with IPERS. Members may also designate their beneficiary through the IPERS website. The designation of a beneficiary by a retiring member on the application for monthly benefits revokes all prior designation of beneficiary forms. IPERS may consider as valid a designation of beneficiary form filed with the member's employer prior to

the death of the member, even if that form was not forwarded to IPERS prior to the member's death. If a retired member is reemployed in covered employment, the most recently filed beneficiary form shall govern the payment of all death benefits for all periods of employment. Notwithstanding the foregoing sentence, a reemployed IPERS Option 4 or 6 retired member may name someone other than the member's contingent annuitant as beneficiary, but only for lump sum death benefits accrued during the period of reemployment and only if the contingent annuitant has died or has been divorced from the member before or during the period of reemployment unless a qualified domestic relations order (QDRO) directs otherwise. If a reemployed IPERS Option 4 or 6 retired member dies without filing a new beneficiary form, the death benefits accrued for the period of reemployment shall be paid to the member's contingent annuitant, unless the contingent annuitant has died or been divorced from the member. If the contingent annuitant has been divorced from the member, any portion of the lump sum death benefits awarded in a QDRO shall be paid to the contingent annuitant as alternate payee, and the remainder of the lump sum death benefits shall be paid to the member's estate or, if applicable, to the member's heirs if no estate is probated. A funeral home shall not be designated as a beneficiary.

14.3(2) *Deceased beneficiary.* If a named beneficiary predeceased the member, that beneficiary's share shall be paid to the surviving named beneficiaries in equal shares.

14.3(3) *Change of beneficiary.* The beneficiary may be changed by the member by filing a new designation of beneficiary form with IPERS. Members may also change their beneficiary through the IPERS website. The latest dated designation of beneficiary form on file shall determine the identity of the beneficiary. Payment of a refund to a terminated member cancels the designation of beneficiary on file with IPERS.

14.3(4) *Spousal signature.* If the member designates someone other than a spouse as the sole primary beneficiary, the beneficiary designation form must contain a spousal signature, pursuant to Iowa Code section 97B.44. If a member's spouse cannot be located, the spousal signature requirement may be waived upon receipt of the notarized form specified by IPERS.

[ARC 1887C, IAB 2/18/15, effective 3/25/15; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 4337C, IAB 3/13/19, effective 4/17/19; ARC 5027C, IAB 4/8/20, effective 5/13/20; ARC 5489C, IAB 3/10/21, effective 4/14/21]

495—14.4(97B) Applications for death benefits. Before death benefit payments can be made, application in writing must be submitted to IPERS with a copy of the member's death certificate, or if a death certificate cannot be obtained, IPERS may rely on such resources as it has available, including but not limited to records from the Social Security Administration, bureau of health statistics, IPERS' own internal records, or reports derived from other public records, and other departmental or governmental records to which IPERS may have access together with information establishing the claimant's right to payment. A named beneficiary must complete an IPERS application for death benefits based on the deceased member's account. If the claimant's claim is based on dissolution of marriage that revoked the IPERS beneficiary designation, the claim must be processed pursuant to rule 495—14.16(97B).

[ARC 1887C, IAB 2/18/15, effective 3/25/15; ARC 2402C, IAB 2/17/16, effective 3/23/16; ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—14.5(97B) Commuted lump sums.

14.5(1) *Designated beneficiary is an estate, trust, church, charity, or similar organization.* Where the designated beneficiary is an estate, trust, church, charity or similar organization, or is a person, such as a trustee, executor, or administrator who has been appointed to receive funds on behalf of such entities, payment of benefits shall be made in a lump sum only.

14.5(2) *Multiple beneficiaries.* Where multiple beneficiaries have been designated by the member, payment, including the payment of the remainder of a series of guaranteed annuity payments, shall be made in a lump sum only. The lump sum payment shall be paid to the multiple beneficiaries in equal shares.

14.5(3) *Guaranteed payments.* Where a member has selected Option 5 and dies before receiving all guaranteed payments, and the member's designated beneficiary also dies before all guaranteed payments are made, any remaining guaranteed payments shall be paid in a commuted lump sum.

[ARC 8929B, IAB 7/14/10, effective 6/21/10; ARC 9068B, IAB 9/8/10, effective 10/13/10]

495—14.6(97B) Payment of the death benefit when no designation of beneficiary or an invalid designation of beneficiary form is on file. When no designation of beneficiary or an invalid designation of beneficiary form is on file with IPERS, payment shall be made in one of the following ways.

14.6(1) Where the estate is open, payment shall be made to the administrator or executor where said executor or administrator shall be duly appointed and serving under Iowa Code chapter 633 or 635.

14.6(2) Where no estate is probated or the estate is closed prior to the filing with IPERS of an application for death benefits, payment will be made in accordance with the intestacy laws of the state of Iowa. If someone other than those identified pursuant to the intestacy laws of the state of Iowa claims entitlement to a death benefit, an estate must be opened and the death benefit shall be payable to the administrator or executor of the estate.

[ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—14.7(97B) Waiver of beneficiary rights. A named beneficiary of a deceased member may waive current and future rights to payments to which the beneficiary would have been entitled. The waiver of the rights shall occur prior to the receipt of a payment from IPERS to the beneficiary. The waiver of rights shall be binding and will be executed on a form provided by IPERS. The waiver of rights may be general, in which case payment shall be divided equally among all remaining designated beneficiaries or, if there are none, to the member's estate. The waiver of rights may also expressly be made in favor of one or more of the member's designated beneficiaries or the member's estate. If the waiver of rights operates in favor of the member's estate and no estate is probated or claim made, or if the executor or administrator expressly waives payment to the estate, payment shall be paid to the member's surviving spouse unless there is no surviving spouse or the surviving spouse has waived the surviving spouse's rights. In that case, payment shall be made to the member's heirs excluding any person who waived the right to payment. Any waiver filed by an executor, administrator, or other fiduciary must be accompanied by a release acceptable to IPERS indemnifying IPERS from all liability to beneficiaries, heirs, or other claimants for any waiver executed by an executor, administrator, or other fiduciary.

495—14.8(97B) Beneficiaries under the age of 18. Payment may be made to a conservator if the beneficiary is under the age of 18 and the total dollar amount to be paid by IPERS to a single beneficiary is \$25,000 or more. Payment may be made to a custodian if the total dollar amount to be paid by IPERS to a single beneficiary is less than \$25,000.

495—14.9(97B) Simultaneous deaths. IPERS will apply the provisions of the Uniform Simultaneous Death Act, Iowa Code sections 633.523 et seq., in determining the proper beneficiaries of death benefits in applicable cases.

495—14.10(97B) Felonious deaths. IPERS will apply the provisions of the Felonious Death Act, Iowa Code sections 633.535 et seq., in determining the proper beneficiaries of death benefits in applicable cases.

495—14.11(97B) No interest on postretirement death benefits. Interest is only accrued on a member's death benefit if the member dies before the member's first month of entitlement (FME) or, for a retired reemployed member, before the member's reemployment FME, and is only accrued with respect to the retired or retired reemployed member's accumulated contributions account.

495—14.12(97B) Preretirement death benefits.

14.12(1) Death prior to first month of entitlement. Where an active member, or an inactive member vested by service, dies prior to the first month of entitlement, the lump sum death benefit shall be the greater of the amount provided in subrule 14.12(3) or 14.12(4). Sole beneficiaries may elect, in lieu of the lump sum amount, to receive a single life annuity that is the actuarial equivalent of such lump sum amount. Where an inactive member, not vested by service, dies prior to the first month of entitlement, the lump sum death benefit shall be as provided in subrule 14.12(7).

14.12(2) Death benefits under Iowa Code section 97B.52(1).

a. Definitions.

“*Accrued benefit*” means the monthly amount that would have been payable to the deceased member under IPERS Option 2 at the member’s earliest normal retirement age, based on the member’s covered wages and service credits at the date of death. If a deceased member’s wage record consists of a combination of regular and special service credits, the monthly amount that would have been payable to the deceased member under Option 2 at the member’s earliest normal retirement age shall be determined separately for regular and special service credits, and then combined.

“*Nearest age*” means a member’s or beneficiary’s age expressed in whole years, after rounding for partial years of age. Ages shall be rounded down to the nearest whole year if less than six complete months have passed following the month of the member’s or beneficiary’s last birthday, and shall be rounded up if six complete months or more have passed following the month of the member’s or beneficiary’s last birthday.

b. Process for applying.

(1) A claim for a single life annuity under this subrule must be filed as follows:

1. A nonspouse beneficiary must file a claim for a single life annuity within 12 months of the member’s death.

2. A beneficiary who is a surviving spouse must file a claim for a single life annuity within 12 months of the member’s death, or by the date that the member would have attained the age of 72, whichever period is later.

(2) Elections to receive the lump sum amount or single life annuity shall be irrevocable once the first payment is made.

(3) No further benefits will be payable following the death of any beneficiary who qualifies and elects to receive the single life annuity provided under this subrule.

(4) The provisions of this subrule shall not apply to members who died before January 1, 2001.

14.12(3) *Accumulated contributions lump sum benefit.* An accumulated contribution lump sum death benefit is equal to the accumulated contributions of the member plus the product of an amount equal to the highest year of covered wages of the deceased member and the number of years of membership service divided by the “applicable denominator,” as provided in Iowa Code section 97B.52(1)“a.” The calculation of the highest year of covered wages shall use the highest calendar year of covered wages reported to IPERS.

14.12(4) *Present value lump sum.* A lump sum death benefit equal to the present value of the member’s accrued benefit is calculated as follows:

a. IPERS shall calculate a member’s retirement benefit at earliest normal retirement age under IPERS Option 2, based on the member’s covered wages and service credits at the date of death and the retirement benefit formula in effect in the month following the date of death.

b. For purposes of determining the “member date of death annuity factor” under the conversion tables supplied by IPERS’ actuary, IPERS shall assume that “age” means the member’s nearest age at the member’s date of death.

c. For purposes of determining the “member unreduced retirement annuity factor” under the conversion tables supplied by IPERS’ actuary, IPERS shall assume that “age” means the member’s nearest age at the member’s earliest normal retirement date. If a member had already attained the member’s earliest normal retirement date, IPERS shall assume that “age” means the member’s nearest age at the date of death.

14.12(5) *Single life annuity benefit.* Procedures and assumptions for converting the actuarial equivalent of a lump sum death benefit to a single life annuity are as follows:

a. For purposes of determining the “age of beneficiary annuity factor” under the conversion tables supplied by IPERS’ actuary, IPERS shall assume that “age” means the beneficiary’s nearest age as of the beneficiary’s first month of entitlement.

b. A beneficiary’s first month of entitlement is the month after the date of the member’s death.

c. Effective for claims filed after June 30, 2004, no retroactive payments of the single life annuity shall be made under this subrule.

d. Effective for claims filed after June 30, 2004, the beneficiary whose single life annuity is less than \$600 per year shall be able to receive only the lump sum payment under this rule.

e. Any sole beneficiary who is eligible for and elects to receive a single life annuity under this subrule shall also qualify for the favorable experience dividend (FED) payments authorized under rule 495—15.2(97B), subject to the requirements of that rule.

14.12(6) Retired reemployed members and aged 70 members who retire without terminating employment. Preretirement death benefits for retired reemployed members and aged 70 members who retire without terminating employment shall be calculated as follows:

a. For beneficiaries of such members who elect IPERS Option 4 or 6 at retirement, IPERS shall recompute (for retired reemployed members) or recalculate/recompute (for aged 70 members who retired without terminating employment) the member's monthly benefits as though the member had elected to terminate employment as of the date of death, to have the member's benefits adjusted for postretirement wages, and then lived into the recomputation or recalculation/recomputation (as applicable) first month of entitlement.

b. The recomputation provided under paragraph 14.12(6)“*a*” shall apply only to beneficiaries of members who elected IPERS Option 4 or 6, where the member's monthly benefit would have been increased by the period of reemployment, and is subject to the limitations of Iowa Code sections 97B.48A, 97B.49A, 97B.49B, 97B.49C, 97B.49D, and 97B.49G. The recalculation/recomputations provided under paragraph 14.12(6)“*a*” shall apply only to beneficiaries of members who elected IPERS Option 4 or 6, where the member's monthly benefit would have been increased by the period of employment after the initial retirement, and is subject to the limitations of Iowa Code sections 97B.49A, 97B.49B, 97B.49C, 97B.49D, and 97B.49G. In all other cases, including cases where members previously received a lump sum payment under Iowa Code section 97B.48(1) in lieu of a monthly retirement allowance, preretirement death benefits under this paragraph shall be the lump sum amount equal to the accumulated employee and accumulated employer contributions.

c. Beneficiaries of members who had elected IPERS Option 4 or 6 may also elect to receive the accumulated employer and accumulated employee contributions described in paragraph 14.12(6)“*b*” in lieu of the increased monthly annuity amount. Notwithstanding paragraph 14.12(6)“*b*” above, if the member elected IPERS Option 5 at retirement, the lump sum amount payable under this paragraph shall be the greater of the applicable commuted lump sum or the accumulated employee and accumulated employer contributions.

14.12(7) Inactive member, not vested by service death benefit.

a. For deaths occurring after June 30, 2004, and before July 1, 2012, for inactive members who have less than 16 quarters of service credit, preretirement death benefits shall be provided solely under Iowa Code section 97B.52(1)“*a*,” and shall only be payable in lump sum amounts. For purposes of this paragraph, an inactive member is a member as defined under Iowa Code section 97B.1A(12).

b. For deaths occurring after June 30, 2012, preretirement death benefits shall be provided solely under Iowa Code section 97B.52(1)“*a*” and shall only be payable in lump sum amounts for inactive members who are not vested by service. For purposes of this paragraph, an inactive member is a member as defined under Iowa Code section 97B.1A(12).

[ARC 0017C, IAB 2/22/12, effective 3/28/12; ARC 2402C, IAB 2/17/16, effective 3/23/16; ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—14.13(97B) Procedures for deaths of certain voluntary emergency services personnel occurring in the line of duty. Effective July 1, 2006, for a member who dies while performing the functions of a voluntary emergency services provider as described under Iowa Code section 85.61 or 147A.1, benefits for deaths occurring in the line of duty shall be paid pursuant to Iowa Code section 100B.31.

[ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—14.14(97B) Rollovers by nonspouse beneficiaries. Effective January 1, 2007, nonspouse beneficiaries shall be permitted to request a direct rollover of such beneficiaries' death benefit payments to traditional IRA accounts established in accordance with Section 829 of the Pension Protection Act

of 2006 and IRS Notice 2007-7. IPERS shall determine the amount eligible for direct rollover under IRC Section 401(a)(9), if any, and the procedural requirements for requesting such rollovers. It shall be the beneficiaries' responsibility to determine that the recipient IRAs meet the structural and operational requirements of Section 829 and Notice 2007-7. IPERS shall bear no responsibility for rollovers to IRA accounts that fail to meet such requirements.

Effective January 1, 2008, IPERS will also allow rollovers under this rule to Roth IRA accounts established in accordance with the structural and operational requirements of Section 829 and Notice 2007-7.

[ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—14.15(97B) Required minimum distribution (RMD) basic calculation.

14.15(1) The RMD for a member who retired under an option with a lump sum death benefit and died after the member's required beginning date (RBD) is calculated as follows:

a. Step 1. Determine the number of payments remaining for the calendar year in which the member died. The current month's payment is not used in this calculation.

b. Step 2. Multiply the number of remaining payments determined in Step 1 by the gross amount of the member's last monthly payment to get the RMD amount. If the lump sum death benefit is less than the RMD, then the RMD is the lump sum death benefit amount.

c. Step 3. Determine the total non-RMD amount by subtracting the RMD as determined in Step 2 from the lump sum death benefit.

d. The eligible rollover amount is the total non-RMD amount as determined in Step 3.

14.15(2) In order to allocate nontaxable amounts between RMD and non-RMD, the calculation is performed as follows:

a. Nontaxable amounts are allocated first to the RMD portion of the lump sum death benefit.

b. If the nontaxable amounts are greater than the RMD amount, the remaining nontaxable amounts are allocated to the non-RMD portion of the lump sum amount.

c. If the nontaxable amounts are less than the RMD amount, the remaining portion of the RMD amount is composed of taxable amounts.

[ARC 8929B, IAB 7/14/10, effective 6/21/10; ARC 9068B, IAB 9/8/10, effective 10/13/10; ARC 5027C, IAB 4/8/20, effective 5/13/20]

495—14.16(97B) Beneficiary revocation pursuant to Iowa Code section 598.20B, dissolution of marriage. IPERS is not liable for the payment of death benefits to a beneficiary pursuant to a beneficiary designation that has been revoked or reinstated by a divorce, annulment, or remarriage before IPERS receives the written notice set forth in subrule 14.16(1). Furthermore, IPERS shall only be liable for payments made after receipt of such written notice if the written notice is received at least ten calendar days prior to the payment.

14.16(1) *Form of notice.* The written notice shall include the following information:

a. The name of the deceased member,

b. The name of the person(s) whose entitlement to IPERS death benefits is being challenged,

c. The name, address, and telephone number of the person(s) asserting an interest,

d. A statement that the decedent's divorce, annulment, or remarriage revoked the entitlement of the person(s) whose status is being challenged to the IPERS death benefits in question, and

e. A copy of the divorce decree upon which the claim is based.

In addition to the above information, if the person whose entitlement is being challenged is not the former spouse, the written notice must indicate that the person was related to the former spouse, but not the member, by blood, adoption or affinity, and state the nature of the relationship.

14.16(2) *Delivery of notice.* Written notice under this rule must be addressed to IPERS General Counsel and mailed to IPERS by registered mail or served upon IPERS in the same manner as a summons in a civil action.

14.16(3) *Administration.* Upon receipt of written notice that meets the requirements of subrules 14.16(1) and 14.16(2):

a. IPERS shall review the deceased member's account and determine if there are moneys left to be distributed from the account.

b. IPERS shall pay the amounts owed, if any, to the probate court having jurisdiction over the decedent's estate, if the deceased member has an open estate.

c. IPERS shall pay the amounts owed, if any, to the probate court that had or would have had jurisdiction over the decedent's estate, if the deceased member's estate is closed or an estate was not opened.

d. As IPERS makes applicable payments, a copy of the written notice received by IPERS shall be filed with the probate court.

If the probate court charges a filing fee for the deposit of amounts payable hereunder, IPERS shall deduct such filing fees and other court costs from the amounts payable prior to transfer. The probate court shall hold the funds and, upon its determination, shall order disbursement or transfer in accordance with the determination. Additional filing fees and court costs, if any, shall be charged upon disbursement either to the recipient or against the funds on deposit with the probate court, in the discretion of the court.

14.16(4) Release of claims. Payments made to a probate court under this rule shall discharge IPERS from all claims by all persons for the value of amounts paid the court.

[ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 8929B, IAB 7/14/10, effective 6/21/10; ARC 9068B, IAB 9/8/10, effective 10/13/10; ARC 5027C, IAB 4/8/20, effective 5/13/20]

These rules are intended to implement Iowa Code sections 97B.1A(8), 97B.1A(18), 97B.1A(19), 97B.34, 97B.34A, 97B.44, 97B.52 and 97B.53B and 2000 Iowa Acts, chapter 1077, section 75.

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CHAPTER 17
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

495—17.1(17A,22) Definitions. As used in this chapter:

“*Confidential record*” means a record which is not available as a matter of right for examination and copying by members of the public under applicable provisions of law. Confidential records include records or information as described in Iowa Code section 97B.17, and records, or information contained in records, that are specified in Iowa Code section 22.7, or by other provision of law.

“*Custodian*” means the CEO or designee.

“*Open record*” means a record other than a confidential record.

“*Personally identifiable information*” means information about or pertaining to an individual in a record which identifies the individual and which is contained in a record system under the jurisdiction of the agency.

“*Record*” means all or part of a “public record” as defined in Iowa Code section 22.1 or 97B.17 which is owned by or in the physical possession of the agency. IPERS also defines a record as information stored or preserved regardless of physical form. Record content, not record form, determines whether or not information constitutes a record. Any information documenting official final business, whether recorded on paper, reproduced on microfilm, entered in an electronic database, documented photographically, recorded in video or audio media, or documented using any other medium, constitutes a record. A record that is not confidential or otherwise exempt by federal or state law is termed an open record.

“*Record system*” means any group of records under the jurisdiction of the agency from which a confidential record or information may be retrieved.

[ARC 1887C, IAB 2/18/15, effective 3/25/15]

495—17.2(17A,22) Statement of policy, purpose and scope. The purpose of this chapter is to facilitate public access to open records. It also seeks to facilitate agency determinations with respect to the handling of confidential records and the implementation of the fair information practices Act. This chapter implements Iowa Code section 22.11 by establishing rules, policies, and procedures for the maintenance of employee, member, and other records in the possession of and under the jurisdiction of the agency.

495—17.3(17A,22) Requests for access to records.

17.3(1) Location of record. A request for access to a record under the jurisdiction of the agency shall be directed to the CEO or designee, Iowa Public Employees’ Retirement System (IPERS), 7401 Register Drive, P.O. Box 9117, Des Moines, Iowa 50306-9117.

17.3(2) Office hours. Records shall be made available during all customary office hours which are from 8 a.m. to 4:30 p.m., excluding officially designated holidays.

17.3(3) Request for access. Requests for access to open records may be made in writing, by telephone, electronically or in person. IPERS may request the name, address, telephone number, and the email address (if available) of the person requesting the information to ensure timely delivery of the documentation, search fee, or both, if applicable. All requests for information regarding member accounts must contain the member’s identification number or social security number. Requests shall identify the particular records sought by name or other personal identifier and shall include a description in order to facilitate the location of the record. A person shall not be required to give a reason for requesting an open record. If a search fee is applicable, IPERS will contact the requesting party with an estimate prior to collecting the data.

17.3(4) Response to requests. The custodian is authorized to grant or deny access to agency records according to the provisions of this chapter. The decision to grant or deny access may be delegated to one or more designated employees.

Access to an open record shall be provided promptly upon request, unless the size or nature of the request makes prompt access impractical. However, access to an open record may be delayed for one of the purposes authorized by Iowa Code section 22.8(4) or 22.10(4). The custodian shall inform the

requester of the reason for the delay and an estimate of the length of that delay and, upon request, shall provide a written reply.

The custodian may deny access to the record or information in the record by members of the public only on the grounds that a denial is warranted under Iowa Code section 22.8(4) or 22.10(4), or that it is a confidential record or information, or that its disclosure is prohibited by a court order. Access by members of the public to a confidential record or information is limited by law and, therefore, may generally be provided only in accordance with the provisions of rule 495—17.4(97B) and other applicable provisions of law.

17.3(5) Security of record. Individuals will not be given access to the area where the records are kept. All examination and copying of records shall be done under supervision. Records shall be protected from damage and disorganization.

17.3(6) Copying. A reasonable number of copies may be made at IPERS. If the number of copies is prohibitive or the copying equipment is not available, IPERS may arrange to have copies made elsewhere subject to costs.

17.3(7) Fees.

a. When charged. The agency is authorized to charge fees in connection with the retrieval, restoration, supervision, compiling and copying of records in accordance with Iowa Code section 22.3. To the extent permitted by applicable provisions of law, the payment of fees may be waived when the imposition of fees is inequitable or when a waiver is in the public interest.

b. Copying and postage costs. Price schedules for published records and for copies of records supplied by the agency shall be posted in the agency. Copies of records may be made by or for members of the public at cost, as determined by and posted in the agency. When the mailing of copies of records is requested, the actual costs of mailing may also be charged to the requester.

c. Search and supervisory fee. A fee may be charged for actual expenses in retrieval, restoration, compiling and supervising the examination and copying of requested records. The fee shall be based on the hourly rate of pay of an agency employee who ordinarily would be appropriate and suitable to perform this function and shall be posted in the agency. No fee shall be charged if the records are not made available for inspection. The requester shall be given advance notice of the hourly rate that will be charged in connection with the retrieval, restoration, supervision, compilation and copying of records.

d. Computer-stored information. A fee, as described in the paragraph above, may be charged for the actual expenses related to the retrieval, restoration and copying of information stored in electronic records. IPERS shall not create custom software to elicit information that is not readily available or accessible on the electronic systems as a normal business function.

e. Advance payments. When a requester has previously failed to pay an applicable search fee, full advance payment of future estimated fees of any amount may be required before processing a new or pending request for access to records from that requester.

[ARC 5489C, IAB 3/10/21, effective 4/14/21]

495—17.4(17A,22) Access to confidential records. Under Iowa Code sections 22.7, 97B.17 or other applicable provisions of law, the custodian may disclose certain confidential records to members of the public. Other provisions of law may authorize or require the custodian to release specified confidential records or information under certain circumstances or to particular persons. The following procedures apply to requests for the custodian to permit the examination or copying of a confidential record and are in addition to those specified for requests for access to records in rule 495—17.3(17A,22).

17.4(1) Proof of identity. A person requesting access to a confidential record shall be required to provide proof of identity satisfactory to the custodian.

17.4(2) Requests. A request for access to a confidential record shall be in a form acceptable to the agency. A person requesting access to a confidential record shall be required to sign a statement enumerating the specific grounds alleged to justify access and provide any proof necessary to establish relevant facts.

17.4(3) Notice to subject of record and opportunity to obtain injunction. After the custodian receives a request for access to a confidential record, and before the custodian releases that record, the custodian

may make reasonable efforts to notify any person who is a subject of that record, is identified in that record, and whose address, telephone number, or other personal identifier is contained in that record. The custodian shall give the subject of that confidential record to whom notification is transmitted a reasonable opportunity to seek an injunction under Iowa Code section 22.8 and indicate to the subject of that record the specified period of time during which disclosure will be delayed for that purpose.

17.4(4) Request denied. When the custodian denies a request for access to a confidential record, in whole or in part, the custodian shall notify the requester in writing. The denial shall include:

- a. The name and title of the person responsible for the denial; and
- b. A citation to the statute or other provision of law which prohibits disclosure of the record; or
- c. A citation to the statute vesting discretion in the custodian to deny disclosure of the record and a brief statement of the reasons for the denial to the requester.

17.4(5) Request granted. When the custodian grants a request for access to a confidential record to a particular person, the custodian shall notify that person and indicate any lawful restrictions imposed by the custodian on that person's examination and copying of the record.

[ARC 2402C, IAB 2/17/16, effective 3/23/16]

495—17.5(17A,22) Requests for treatment of a record as a confidential record and its withholding from examination. The custodian may treat a record as confidential and withhold it from examination only to the extent that the custodian is authorized to refuse to disclose the record to members of the public by Iowa Code section 22.7 or 97B.17, another applicable provision of law, or in response to a court order.

17.5(1) Persons who may request. Any person who would be aggrieved or adversely affected by disclosure of all or a part of a record under the jurisdiction of the agency to members of the public and who asserts that Iowa Code section 22.7 or 97B.17, another applicable provision of law, or a court order authorizes the custodian to treat the record as a confidential record, may file a request, as provided for in this rule, for its treatment as a confidential record and to withhold it from public inspection.

17.5(2) Request. A request for the treatment of a record as a confidential record shall be in writing and shall be filed with the custodian. The request shall include an enumeration of the specific reasons justifying confidential record treatment for all or part of that record, the specific provisions of law that authorize confidential record treatment in this instance, and the name, mailing address, telephone number and, if available, the email address of the person authorized to respond to any action concerning the request. If the information is regarding an IPERS member, the member identification number or social security number of the member must be included. The person requesting treatment of a record as a confidential record may also be required to sign a certified statement or affidavit enumerating the specific reasons justifying the treatment of the record as a confidential record and to provide any proof necessary to establish relevant facts. The person filing a request shall, if possible, accompany the request with a redacted copy of the record in question for which confidential record treatment has been requested. If the original record is submitted at the same time the request is filed, the person shall indicate conspicuously on the original record which portions of it are requested to be confidential. Requests for treatment of all or portions of a record as confidential for a limited time period shall also specify the precise period of time for which confidential record treatment is requested.

17.5(3) Failure to request. Failure of a person to request confidential record treatment for a record or confidential information contained in a record shall not preclude the custodian from treating it as a confidential record or the confidential information contained in that record as permitted under Iowa Code section 22.7 or 97B.17. However, if a person who has submitted information does not request confidential record treatment under the provisions of Iowa Code sections 22.7(3) (trade secrets), 22.7(6) (advantage to competitors), and 22.7(18) (communications not required by law, rule, procedure or contract), the custodian of records containing that information may, but is not required to, proceed as if that person has no objection to its disclosure to members of the public.

17.5(4) Timing of decision. A decision by the agency with respect to the disclosure of all or part of a record under its jurisdiction to members of the public may be made when a request for its treatment as a confidential record is filed or when a request is received for access to the record by a member of the public.

17.5(5) *Request granted or deferred.* If a request for a confidential record or information is granted, or if action on a request is deferred, a copy of the record from which the material in question has been deleted and a copy of the decision to grant the request or to defer action on the request will be placed in the original file, and will be made available for public inspection. If a request is subsequently received for access to the original record, reasonable and timely efforts will be made to notify any person who has filed a request for its treatment as a confidential record.

17.5(6) *Request denied and opportunity to seek injunction.* If a request that a record be treated as a confidential record and be withheld from public inspection is denied, the custodian shall notify the requester in writing of the reasons for that determination. On application by the requester, the custodian may engage in a good-faith, reasonable delay in allowing examination of the record so that the requester may seek injunctive relief under the provisions of Iowa Code section 22.8, or other applicable provision of law. However, a record shall not be withheld from public inspection for any period of time if the custodian determines that the requester had no reasonable grounds to justify the treatment of that record as a confidential record. The custodian shall notify requester in writing of the time period allowed to seek injunctive relief or the reasons for the determination that no reasonable grounds exist to justify the treatment of that record as a confidential record. The custodian may extend the period of good-faith, reasonable delay in allowing examination of the record so that the requester may seek injunctive relief only if no request for examination of that record has been received, or if a court directs the custodian to treat it as a confidential record, or to the extent permitted by another applicable provision of law, or with the consent of the person requesting access.

495—17.6(17A,22) Procedure by which a person who is the subject of a record may have additions, dissents, or objections entered into certain records. Except as otherwise provided by law, the subject of a record may file a request with the custodian to review and to have the right to have written additions, dissents, or objections entered into a record under the jurisdiction of the agency. However, this does not authorize a person who is a subject of a record to alter the original copy of the record or to expand the official record of an agency proceeding. The subject shall send the request to review a record or the written statement of additions, dissents or objections to the agency. Additions, dissents, or objections must be dated and signed by the subject, and shall include the current mailing address, telephone number and, if available, the email address of the subject or the subject's representative. The subject's social security number must also be included on the addition.

495—17.7(17A,22) Consent to disclosure by the subject of a confidential record. To the extent permitted by any applicable provision of law, the subject of a confidential record under the jurisdiction of the agency may consent to disclosure to a third party of that portion of the record concerning the subject except as provided in subrule 17.12(1). The consent must be in writing and must identify the particular record or records that may be disclosed, the particular person or class of persons to whom the record may be disclosed and, where applicable, the time period during which the record or information may be disclosed. The subject and, where applicable, the person to whom the record is to be disclosed, must provide proof of identity. Appearance of legal counsel, or a duly appointed representative on behalf of a subject of a confidential record, is deemed to constitute consent for the agency to disclose records about that person to the person's representative.

495—17.8(17A,22) Notice to suppliers of information. When the agency requests a person to supply information about that person, the agency shall notify the person of the use that will be made of the information, which persons outside the agency might routinely be provided the information, which parts of the requested information are required and which are optional, and the consequences of a failure to provide the information requested. This notice may be given in rules, on the written form used to collect the information, on a separate fact sheet or letter, in brochures, in formal agreements, in contracts, in handbooks, in manuals, verbally, or by other appropriate means.

495—17.9(17A,22) Disclosures without the consent of the subject.

17.9(1) Open records shall be routinely disclosed without the consent of the subject.

17.9(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 495—17.10(97B) or in the notice for a particular record system.

b. To a recipient who has provided 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 government 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 the authorized representative of the government agency or instrumentality has submitted a written request to the custodian specifying the record desired and the law enforcement activity for which the record is sought.

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

e. To the legislative services agency.

f. In the course of employee disciplinary proceedings.

g. In response to a court order or subpoena.

495—17.10(17A,22) Routine use.

17.10(1) Defined. “Routine use” means the disclosure of a record, without the consent of the subject or subjects, for a purpose which is compatible with the purpose for which the record was collected. It includes disclosures required or permitted to be made by statute other than the public records law, Iowa Code chapter 22.

17.10(2) To the extent allowed by law, the following uses 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 duties. The CEO or designee shall resolve disputes concerning what constitutes legitimate need to use confidential or exempt 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 for matters in which it is performing services or functions on behalf of an agency.

d. Transfers of information within an 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, state, or other governmental entities for audit purposes or for purposes of determining whether an agency is operating a program lawfully.

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

g. Disclosure to officers, employees and agents of the agency who need to use the record to determine the named beneficiary when a wage earner or retiree dies; to maintain a record of wages reported and quarters worked for computation of benefits; to track benefits received; to recompute and adjust benefits; to update information for electronic deposit of benefits; to audit payroll reports; and to verify quarterly update of wages paid.

495—17.11(17A,22) Consensual disclosure of confidential records.

17.11(1) *Consent to disclosure by a subject individual.* The subject may consent in writing to disclosure of confidential records as provided in rule 495—17.7(97B).

17.11(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 a record under the jurisdiction of the agency may be treated as an authorization to release sufficient information about the subject to the official to resolve the matter. The public official shall be required to treat the information received as confidential.

17.11(3) *Obtaining information from a third party.* The agency may be required to obtain information to coordinate benefits, verify applicant and employee information or to provide other services. Requests to third parties for this information may involve the release of confidential identifying information about individuals contained in records under the jurisdiction of the agency. Such requests are within the meaning of routine use as defined in rule 495—17.10(97B) and shall not require authorization from the subject of the record.

495—17.12(17A,22) Release to subject.

17.12(1) Records shall be released to the subject of a confidential record upon a written request from the subject. The agency need not release the following records or information to the requester:

- a. The identity of a person providing information about the requester when the information is authorized to be held confidential pursuant to Iowa Code section 22.7(18).
- b. Records that are the work products of an attorney or are otherwise privileged.
- c. Peace officers' criminal investigative reports except as required by the Iowa Code. See Iowa Code section 22.7(5).
- d. As otherwise authorized by law or covered as an investigative request required by the system.

17.12(2) Where a record has multiple persons with interest in the confidentiality of the record, reasonable steps shall be taken to protect confidential information relating to other persons in the record.

495—17.13(17A,22) Availability of records.

17.13(1) *Open records.* Records under the jurisdiction of the agency are open for public inspection and copying unless otherwise provided by these rules.

17.13(2) *Confidential records.* The following records under the jurisdiction of the agency 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. See Iowa Code section 72.3.
- b. Procurement proposals prior to completion of the evaluation process and the issuance of a notice of intent to award a contract, provided that, if requests for proposals are canceled prior to the issuance of a notice of intent to award, all procurement proposals shall be returned in confidence to the bidders and no file copies shall be retained.
- c. Tax records made available to the agency.
- d. Records which are exempt from disclosure under Iowa Code sections 22.7 and 97B.17, including, but not limited to:
 - (1) Communications not required by rule, law, procedure or contract to the extent that the agency reasonably believes that such communications would not be made if the supplier knew the information would be made available for general public examination. These records are confidential under Iowa Code section 22.7(18).
 - (2) Data processing software, as defined in Iowa Code section 22.3A, which is developed by a governmental body.
 - (3) Log-on identification passwords, Internet protocol addresses, usernames, private keys, or other records containing information which might lead to disclosure of private keys used in a digital signature or other similar technologies as provided in Iowa Code chapter 554D.
 - (4) Records which if disclosed might jeopardize the security of an electronic transaction pursuant to Iowa Code chapter 554D.
- e. Minutes of closed meetings of a government body under Iowa Code section 21.5(4).

f. 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 section 17A.3(1) “e.”

g. Those portions of agency manuals, examination materials, instructions or other statements issued which set forth criteria or guidelines to be used in auditing, in making inspections, in settling commercial disputes or negotiating commercial contract arrangements, or in the selection or handling of cases, such as operational tactics on 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.

h. 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) and 622.10, Iowa R.C.P. 1.503, Fed. R.Civ.P. 26(b)(3), and case law. Attorney-client communications are confidential under Iowa Code section 622.10, the rules of evidence, the Code of Professional Responsibility, and case law.

i. Any other records made confidential by law.

17.13(3) Authority to release confidential records. The agency, under certain circumstances, may disclose some information or confidential records which otherwise are exempt from disclosure under Iowa Code sections 22.7 and 97B.17, or other law. Any person may request permission to inspect particular records withheld from inspection as confidential records. If it is initially determined that records will be released, reasonable efforts will be made, where appropriate, to notify interested persons, and the records may be withheld from inspection for up to ten days to allow interested persons to seek injunctive relief.

[ARC 5489C, IAB 3/10/21, effective 4/14/21]

495—17.14(17A,22) Personally identifiable information. This rule describes the nature and extent of personally identifiable information which is collected, maintained, and retrieved by personal identifier in record systems defined in rule 495—17.1(97B). For each record system, this rule describes the legal authority for the collection of that information and the means of storage of that information, and indicates whether a data processing system matches, collates, or permits the comparison of personally identifiable information in one record system with personally identifiable information in another record system. Record systems under the jurisdiction of the agency that are retrievable through the use of personal identifiers are described as follows:

17.14(1) IPERS personnel files and records. Personnel files of IPERS employees are maintained and kept under the jurisdiction of the agency and contain personal, private, and otherwise confidential records under Iowa Code section 22.7(11). It is unlikely that the personal and private information in these records can be separated from otherwise releasable information without identifying the subject or the employee’s family. These records contain names, social security numbers and other identifying numbers. Data processing systems permit the comparison of personally identifiable information in one record system with that in another system.

17.14(2) Iowa public employees’ retirement system. The retirement system possesses records that concern individual public employees who are covered by IPERS and their families. Records are collected in accordance with Iowa Code chapter 97B and are confidential records in part under Iowa Code sections 22.7 and 97B.17. These records contain names, addresses, social security numbers, and other identifying numbers. Data processing systems permit the comparison of personally identifiable information in one record system with that in another system.

17.14(3) Vendor contracts. These are records pertaining to facilities management, training, investment management, and other services. These records are collected in accordance with Iowa Code chapter 97B and are confidential records in part under Iowa Code section 22.7. These records contain names, addresses, social security numbers, and other identifying numbers. Data processing systems permit the comparison of personally identifiable information in one record system with that in another

system. Vendors that have access to personally identifiable information shall sign a data-sharing agreement as requested by IPERS.

[ARC 5489C, IAB 3/10/21, effective 4/14/21]

495—17.15(17A,22) Other groups of records routinely available for public inspection. This rule describes groups of records maintained by the agency other than those record systems retrieved by personally identifiable information as defined in rule 495—17.1(97B). These records are routinely available to the public subject to costs. However, these records may contain confidential information. In addition, the records listed in subrules 17.15(1) to 17.15(4), 17.15(6), and 17.15(9) may contain information about individuals. All records may be stored on paper, microfilm, tape or in automated data processing systems unless otherwise noted.

17.15(1) Rule-making records. Rule-making records may identify individuals making written or oral comments on proposed rules. This information is collected pursuant to Iowa Code section 17A.4. Public documents generated during the promulgation of agency rules, including notices and public comments, are available for public inspection. This information is not retrieved by individual identifier.

17.15(2) Board and committee records. Agendas, minutes, and materials presented to the board and committee within the agency are available from the agency except those records concerning closed sessions which are exempt from disclosure under Iowa Code section 21.5(4) or which are otherwise confidential by law. These records may identify individuals who participate in meetings. This information is collected pursuant to Iowa Code section 21.3. This information is not retrieved by individual identifier.

17.15(3) Publications. News releases, annual reports, final project reports, newsletters, and brochures describing various programs are available from the agency. These publications may contain information about individuals, including staff or members of the board or committee. This information is not retrieved by individual identifier.

17.15(4) Statistical reports. Periodic reports of activity for various department programs are available from the department. This information is not retrieved by individual identifier.

17.15(5) Appeal decisions and advisory opinions. All final orders, decisions and opinions are open to the public except for information that is confidential according to rule 495—17.5(97B) or subrule 17.13(2). These records, collected under the authority of Iowa Code chapters 97B and 97C, may contain confidential information about individuals.

17.15(6) Published materials. The agency uses many legal and technical publications in its work. The public may inspect these publications upon request. Some of these materials may be protected by copyright laws. This information is not retrieved by individual identifier.

17.15(7) Policy manuals. The agency's manuals containing the policies and procedures for programs administered by the agency are available at IPERS' headquarters. This information is not retrieved by individual identifier.

17.15(8) Administrative records. These are records related to the budgets of the agency, the requisition of equipment and supplies, the payment of claims, and other accounting functions as well as records kept by the investments section, including information on investment policies and portfolios. Some investment information is partially confidential under Iowa Code sections 22.7 and 97B.17.

17.15(9) All other records not exempted from disclosure by law.

495—17.16(17A,22) Comparison of data processing systems. To the extent required by law, all data processing systems used by the agency permit the comparison of personally identifiable information in one record system with personally identifiable information in another record system.

495—17.17(17A,22) Applicability. This chapter does not:

1. Make available to the general public records which contain information about individuals by that person's name or other personal identifier.
2. Make records available to the general public which would otherwise not be available under the public records law, Iowa Code chapter 22 and Iowa Code section 97B.17.

3. Govern the maintenance or disclosure of, notification of, or access to records in the possession of the agency which are under the jurisdiction of another agency.

4. Apply to grantees, including local governments or their subdivisions, administering state-funded programs unless otherwise provided by law or agreement.

5. Make available records compiled in reasonable anticipation of court litigation or formal administrative proceedings. The availability of those records to the general public or to any individual or party to litigation or proceedings shall be governed by applicable legal and constitutional principles, statutes, rules of discovery, evidentiary privileges, and applicable regulations of the agency.

6. Require the agency to create, compare or procure a record solely for the purpose of making it available.

These rules are intended to implement Iowa Code chapter 97B.

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CHAPTER 19
DECLARATORY ORDERS

495—19.1(17A) Petition for declaratory order. Any person may file a petition with the agency for a declaratory order regarding the applicability to specified circumstances of a statute, rule, or order within the primary jurisdiction of the agency. Such petitions shall be addressed to the CEO or CEO’s designee, IPERS, 7401 Register Drive, P.O. Box 9117, Des Moines, Iowa 50306-9117. A petition is deemed filed when it is received by the agency.

The agency shall provide the petitioner with a date-stamped copy of the petition if the petitioner provides an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

IOWA PUBLIC EMPLOYEES’ RETIREMENT SYSTEM (IPERS)	
Petition by (Name of Petitioner) for a Declaratory Order on (Cite provisions of law involved).	}
PETITION FOR DECLARATORY ORDER	

The petition must provide the following information:

1. A clear and concise statement of all relevant facts on which the order is requested.
2. A citation and the relevant language of the specific statutes, rules, policies, decisions, or orders, whose applicability is questioned, and any other relevant law.
3. The questions petitioner wants answered, stated clearly and concisely.
4. The answers to the questions desired by the petitioner and a summary of the reasons urged by the petitioner in support of those answers.
5. The reasons for requesting the declaratory order and disclosure of the petitioner’s interest in the outcome.
6. A statement indicating whether the petitioner is currently a party to another proceeding involving the questions at issue and whether, to the petitioner’s knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
7. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the questions presented in the petition.
8. Any request by petitioner for a meeting pursuant to 495—19.7(17A).

The petition must be dated and signed by the petitioner or the petitioner’s representative. It must also include the name, mailing address, and telephone number of the petitioner and petitioner’s representative and a statement indicating the person to whom communications concerning the petition should be directed.

[ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 5489C, IAB 3/10/21, effective 4/14/21]

495—19.2(17A) Notice of petition. Within 15 days after receipt of a petition for a declaratory order, the agency shall give notice of the petition to all persons not served by the petitioner pursuant to rule 495—19.7(17A) to whom notice is required by any provision of law. Notice may also be given to any other person.

495—19.3(17A) Intervention.

19.3(1) Persons who qualify under any applicable provision of law as an intervenor and who file a petition for intervention within 20 days of the filing of a petition for declaratory order shall be allowed to intervene in a proceeding for a declaratory order.

19.3(2) Any person who files a petition for intervention at any time prior to the issuance of an order may be allowed to intervene in a proceeding for a declaratory order at the discretion of the agency.

19.3(3) A petition for intervention shall be filed with the CEO or CEO’s designee at IPERS, 7401 Register Drive, P.O. Box 9117, Des Moines, Iowa 50306-9117. Such a petition is deemed filed when it is received by IPERS.

The agency will provide the petitioner with a date-stamped copy of the petition for intervention if the petitioner provides an extra copy for this purpose. A petition for intervention must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

IOWA PUBLIC EMPLOYEES' RETIREMENT SYSTEM (IPERS)	
Petition by (Name of Original Petitioner) for a Declaratory Order on (Cite provisions of law in original petition).	} PETITION FOR INTERVENTION

The petition for intervention must provide the following information:

1. Facts supporting the intervenor's standing and qualifications for intervention.
2. The answers urged by the intervenor to the question or questions presented in the original petition for declaratory order, and a summary of the reasons urged in support of those answers.
3. Reasons for requesting intervention and disclosure of the intervenor's interest in the outcome.
4. A statement indicating whether the intervenor is currently a party to any proceeding involving the questions at issue and whether, to the intervenor's knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
5. The names and addresses of any additional persons, or a description of any additional class of persons, known by the intervenor to be affected by, or interested in, the questions presented.
6. Whether the intervenor consents to be bound by the determination of the matters presented in the declaratory order proceeding.

The petition must be dated and signed by the intervenor or the intervenor's representative. It must also include the name, mailing address, and telephone number of the intervenor and intervenor's representative, and a statement indicating the person to whom communications should be directed.

[ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 5489C, IAB 3/10/21, effective 4/14/21]

495—19.4(17A) Briefs. The petitioner or any intervenor may file a brief in support of the position urged. The agency may request a brief from the petitioner, any intervenor, or any other person concerning the questions raised.

495—19.5(17A) Inquiries. Inquiries concerning the status of a declaratory order proceeding may be made to the CEO or CEO's designee, IPERS, 7401 Register Drive, P.O. Box 9117, Des Moines, Iowa 50306-9117.

[ARC 2981C, IAB 3/15/17, effective 4/19/17]

495—19.6(17A) Service and filing of petitions and other papers.

19.6(1) When service required. Except where otherwise provided by law, every petition for declaratory order, petition for intervention, brief, or other paper filed in a proceeding for a declaratory order shall be served upon each of the parties of record to the proceeding, and on all other persons identified in the petition for declaratory order or petition for intervention as affected by or interested in the questions presented, simultaneously with their filing. The party filing a document is responsible for service on all parties and other affected or interested persons.

19.6(2) When filing required. Petitions for declaratory orders, petitions for intervention, briefs, or other papers in a proceeding for a declaratory order shall be filed with the CEO or CEO's designee, IPERS, 7401 Register Drive, P.O. Box 9117, Des Moines, Iowa 50306-9117. All petitions, briefs, or other papers that are required to be served upon a party shall be filed simultaneously with the agency.

19.6(3) Method of service. Method of service, time of filing, and proof of mailing shall be as provided by uniform rule on contested cases 495—26.13(17A).

[ARC 2981C, IAB 3/15/17, effective 4/19/17]

495—19.7(17A) Informal meeting. The agency may schedule a brief and informal meeting between the original petitioner, all intervenors, and the agency, a member of the agency, or a member of the staff of the agency to discuss the questions raised. The agency may solicit comments from any person on the questions raised. Also, comments on the questions raised may be submitted to the agency by any person.

495—19.8(17A) Action on petition.

19.8(1) Within 30 days after receipt of a petition for a declaratory order, the CEO or CEO's designee shall take action on the petition pursuant to Iowa Code section 17A.9(5).

19.8(2) The date of issuance of an order or of a refusal to issue an order shall be the date of mailing of a decision or order, or the date of delivery if service is by other means, unless another date is specified in the order.

[ARC 2981C, IAB 3/15/17, effective 4/19/17]

495—19.9(17A) Refusal to issue order.

19.9(1) The agency shall not issue a declaratory order where prohibited by Iowa Code section 17A.9(1). The agency may refuse to issue a declaratory order on some or all questions raised for the following reasons:

- a. The petition does not substantially comply with the required form.
- b. The petition does not contain facts sufficient to demonstrate that the petitioner will be aggrieved or adversely affected by the failure of the agency to issue an order.
- c. The agency does not have jurisdiction over the questions presented in the petition.
- d. The questions presented by the petition are also presented in a current rule making, contested case, or other agency or judicial proceeding, that may definitively resolve them.
- e. The questions presented by the petition would more properly be resolved in a different type of proceeding or by another body with jurisdiction over the matter.
- f. The facts or questions presented in the petition are unclear, overbroad, insufficient, or otherwise inappropriate as a basis upon which to issue an order.
- g. There is no need to issue an order because the questions raised in the petition have been settled due to a change in circumstances.
- h. The petition is not based upon facts calculated to aid in the planning of future conduct but is, instead, based solely upon prior conduct in an effort to establish the effect of that conduct or to challenge an agency decision already made.
- i. The petition requests a declaratory order that would necessarily determine the legal rights, duties, or responsibilities of other persons who have not joined in the petition, intervened separately, or filed a similar petition and whose position on the questions presented may fairly be presumed to be adverse to that of petitioner.
- j. The petitioner requests the agency to determine whether any of the conditions under Iowa Code section 17A.19(8), incorporated by this reference, have been met.
- k. The agency will not issue declaratory orders on the following:
 - (1) The present value of IPERS retirement monthly benefits;
 - (2) Actuarial assumptions used or proposed to be used by the agency;
 - (3) The impact of proposed legislation;
 - (4) Issues which require the disclosure of confidential information; and
 - (5) Any matter under appeal or in litigation.

19.9(2) A refusal to issue a declaratory order must indicate the specific grounds for the refusal and constitutes final agency action on the petition.

19.9(3) Refusal to issue a declaratory order pursuant to this provision does not preclude the filing of a new petition that seeks to eliminate the grounds for the refusal to issue an order.

[ARC 2981C, IAB 3/15/17, effective 4/19/17]

495—19.10(17A) Contents of declaratory order—effective date. In addition to the order itself, a declaratory order must contain the date of its issuance; the name of petitioner and all intervenors; the specific statutes, rules, policies, decisions, or orders involved; the particular facts upon which it is based; and the reasons for its conclusion.

A declaratory order is effective on the date of issuance.

495—19.11(17A) Copies of orders. Copies of all orders issued in response to a petition for a declaratory order shall be mailed promptly to the original petitioner and all intervenors.

495—19.12(17A) Effect of a declaratory order. A declaratory order has the same status and binding effect as a final order issued in a contested case proceeding. It is binding on the agency, the petitioner, and any intervenors who consent to be bound and is applicable only in circumstances where the relevant facts and the law involved are indistinguishable from those on which the order was based. As to all other persons, a declaratory order serves only as precedent and is not binding on the agency. The issuance of a declaratory order constitutes final agency action on the petition.

These rules are intended to implement Iowa Code chapters 17A and 97B.

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NATURAL RESOURCES DEPARTMENT[561]

Created by 1986 Iowa Acts, chapter 1245, section 1802

Rules of divisions under this Department “umbrella” include Energy and Geological Resources[565], Environmental Protection Commission[567], Natural Resource Commission[571], and Preserves, State Advisory Board[575]

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CHAPTER 10
WAIVERS FROM ADMINISTRATIVE RULES

561—10.1(17A,455A) Applicability. This chapter outlines a uniform process for the granting of waivers from rules adopted by the department. As used in this chapter, the term “director” includes the director’s designee. As used in this chapter, “waiver” means an action by the department which suspends in whole or in part the requirements or provisions of a rule as applied to an identified person on the basis of the particular circumstances of that person.

[ARC 5516C, IAB 3/10/21, effective 4/14/21]

561—10.2(17A,455A) Authority. A waiver from rules adopted by the department may be granted in accordance with this chapter if:

10.2(1) The department has exclusive rule-making authority to promulgate the rule from which waiver is requested or has final decision-making authority over a contested case in which a waiver is requested; and

10.2(2) The waiver is consistent with any applicable statute, constitutional provision, or other provision of law. In addition, this subrule does not authorize the department to waive any requirement created or duty imposed by statute.

[ARC 5516C, IAB 3/10/21, effective 4/14/21]

561—10.3(17A,455A) Interpretive rules. The principles of statutory construction contained in Iowa Code chapter 4, “Construction of Statutes,” shall be used when determining whether these rules apply to a specific rule.

561—10.4(17A,455A) Criteria for waiver. Upon petition of any person and at the sole discretion of the department, the department may issue a waiver from the requirements of a rule if the director or the department in a contested case proceeding finds, based on clear and convincing evidence, all of the following:

10.4(1) The application of the rule would pose an undue hardship on the person for whom the waiver is requested.

10.4(2) The waiver from the requirements of a rule in the specific case would not prejudice the substantial legal rights of any person.

10.4(3) The provisions of a rule subject to a petition for a waiver are not specifically mandated by statute or another provision of law.

10.4(4) Substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in the particular rule for which the waiver is requested.

[ARC 5516C, IAB 3/10/21, effective 4/14/21]

561—10.5(17A,455A) Burden of persuasion. The burden of persuasion rests with the person who petitions the department for the waiver of a rule. Each petition for a waiver shall be evaluated by the department based on the unique, individual circumstances set out in the petition. A waiver, if granted, shall be drafted by the department so as to provide the narrowest exception possible to the provisions of the rule. The department may place any condition on a waiver that the department finds desirable to protect the public health, safety, and welfare. A waiver shall not be permanent unless the petitioner can show that a temporary waiver would be impracticable, and, in any event, shall not exceed one year in accordance with the provisions of Iowa Code section 455B.143. If a temporary waiver is granted, there is no automatic right to renewal. At the sole discretion of the department, a waiver may be renewed if the department finds all of the factors set out in rule 561—10.4(17A,455A) remain valid.

[ARC 5516C, IAB 3/10/21, effective 4/14/21]

561—10.6(17A,455A) Special waiver rules not precluded. This chapter shall not preclude the department from granting waivers in other contexts or on the basis of other standards if a statute or other department rule authorizes the director to do so, and the director deems it appropriate to do so.

[ARC 5516C, IAB 3/10/21, effective 4/14/21]

561—10.7(17A,455A) Administrative deadlines. When the rule from which a waiver is sought establishes administrative deadlines, the department shall balance the special individual circumstances of the petitioner with the overall goal of uniform treatment of all persons governed by the particular rule. [ARC 5516C, IAB 3/10/21, effective 4/14/21]

561—10.8(17A,455A) Filing of petition. A petition for a waiver shall be submitted in writing to the department as follows:

10.8(1) Contested cases. If the petition relates to a pending contested case, the petition shall be filed in the contested case proceeding. The department may elect not to rule on the waiver petition until the resolution of the contested case proceeding.

10.8(2) Other. If the petition does not relate to a pending contested case, the petition may be submitted to the director.

[ARC 5516C, IAB 3/10/21, effective 4/14/21]

561—10.9(17A,455A) Contents of petition. A petition for waiver shall include the following information when applicable and known to the petitioner:

10.9(1) The name, address, and telephone number of the entity or person for whom a waiver is requested, and the case number of any related contested case.

10.9(2) A description and citation of the specific rule from which a waiver is requested.

10.9(3) The specific waiver requested, including the precise scope and operative period that the waiver will extend.

10.9(4) The relevant facts that the petitioner believes would justify a waiver. This statement shall include a signed statement from the petitioner attesting to the accuracy of the facts provided in the petition and a statement of reasons that the petitioner believes will justify a waiver.

10.9(5) A history of any prior contacts between the department and the petitioner for the past five years, including a description of each affected permit held by the petitioner, and any notices of violation, administrative orders, contested case proceedings, and lawsuits involving the department and the petitioner.

10.9(6) Any information known to the petitioner regarding the department's treatment of similar cases.

10.9(7) The name, address, and telephone number of any public agency or political subdivision of the state or federal government which also regulates the activity in question, or which might be affected by the granting of a waiver.

10.9(8) The name, address, and telephone number of any person or entity that would be adversely affected by the granting of a petition.

10.9(9) The name, address, and telephone number of any person with knowledge of relevant facts relating to the proposed waiver.

10.9(10) Signed releases of information authorizing persons with knowledge regarding the request to furnish the department with information relevant to the waiver.

[ARC 5516C, IAB 3/10/21, effective 4/14/21]

561—10.10(17A,455A) Additional information. Prior to issuing a decision granting or denying a waiver, the department may request additional information from the petitioner relative to the petition and surrounding circumstances. If the petition was not filed in a contested case, the director may, on the director's own motion or at the petitioner's request, schedule a telephonic or in-person meeting between the petitioner and the director.

[ARC 5516C, IAB 3/10/21, effective 4/14/21]

561—10.11(17A,455A) Notice. The petitioner, within 30 days of submission of the petition, shall serve by certified mail notice of the pending petition and a concise summary of its contents upon all persons to whom notice is required by any provision of law. The petitioner shall provide a written statement to the department attesting that the required notice has been provided. The department shall acknowledge a petition upon receipt and, in addition, the department may give notice to other persons.

561—10.12(17A,455A) Hearing procedures. The provisions of Iowa Code sections 17A.10 to 17A.18A regarding contested case hearings shall apply to any petition for a waiver of a rule filed within a contested case and shall otherwise apply to department proceedings for a waiver only when the department so provides by rule or order or is required to do so by statute.

[ARC 5516C, IAB 3/10/21, effective 4/14/21]

561—10.13(17A,455A) Ruling. A decision granting or denying a waiver shall be in writing and shall contain a reference to the particular person and rule or portion thereof to which the decision pertains, a statement of the relevant facts and reasons upon which the action is based, and a description of the precise scope and operative period of the waiver if one is issued.

[ARC 5516C, IAB 3/10/21, effective 4/14/21]

561—10.14(17A,455A) Conditions. The department may condition the granting of the waiver on such reasonable conditions as appropriate to achieve the objectives of the particular rule in question through alternative means.

[ARC 5516C, IAB 3/10/21, effective 4/14/21]

561—10.15(17A,455A) Time for ruling. The department shall grant or deny a petition for a waiver as soon as practicable but, in any event, shall do so within 120 days of receipt of the petition, unless the petitioner agrees to a later date. However, if a petition is filed in a contested case, the department shall grant or deny the petition no later than the time at which the final decision in that contested case is issued.

[ARC 5516C, IAB 3/10/21, effective 4/14/21]

561—10.16(17A,455A) When deemed denied. Failure of the director or the department in a contested case proceeding to grant or deny a petition within the required time period shall be deemed a denial of that petition by the department.

561—10.17(17A,455A) Service of decision. Within seven days of its issuance, any decision issued under this chapter shall be transmitted to the petitioner or the person to whom the decision pertains and to any other person entitled to such notice by any provision of law.

561—10.18(17A,455A) Public availability. Subject to the provisions of Iowa Code section 17A.3(1)“e,” the department shall maintain a record of all decisions granting and denying waivers under this chapter. All final rulings in response to requests for waivers shall be indexed and available to members of the public.

[ARC 5516C, IAB 3/10/21, effective 4/14/21]

561—10.19(17A,455A) Voiding or cancellation. A waiver is void if the material facts upon which the request is based are not true or if material facts have been withheld. The department may at any time cancel a waiver if the department finds that the facts as stated in the request are not true, material facts have been withheld, the alternative means of compliance provided in the waiver have failed to achieve the objectives of the statute, or the requester has failed to comply with the conditions of the waiver.

[ARC 5516C, IAB 3/10/21, effective 4/14/21]

561—10.20(17A,455A) Violations. Violation of conditions of the waiver approval is the equivalent of violation of the particular rule for which the waiver is granted and is subject to the same remedies or penalties.

[ARC 5516C, IAB 3/10/21, effective 4/14/21]

561—10.21(17A,455A) Defense. After the department issues a decision granting a waiver, the decision is a defense within its terms and the specific facts indicated therein for the person to whom the decision pertains in any proceeding in which the rule in question is sought to be invoked.

[ARC 5516C, IAB 3/10/21, effective 4/14/21]

These rules are intended to implement Iowa Code chapters 17A, 21, 22, and 455A.

[Filed 8/31/01, Notice 2/21/01—published 9/19/01, effective 10/24/01]

[Filed ARC 5516C (Notice ARC 5380C, IAB 1/13/21), IAB 3/10/21, effective 4/14/21]

CHAPTER 12
SPECIAL NONRESIDENT DEER AND TURKEY LICENSES

561—12.1(483A) Purpose. These rules establish the process by which the department will issue special nonresident deer and turkey licenses to individuals as part of statewide or local efforts to promote the state and its natural resources.

[ARC 7814B, IAB 6/3/09, effective 7/8/09]

561—12.2(483A) Definitions. When used in this chapter:

“Approved organization” means an organization that is incorporated under Iowa Code chapter 504 as a nonprofit organization, whose mission involves providing hunting experiences for disabled veterans and military personnel, and that is listed on the IRS exempt organizations list or provides a copy of an IRS determination letter for 501(c) tax-exempt status.

“Conservation organization” means an organization that is licensed and managed pursuant to Iowa Code chapter 504, the revised Iowa nonprofit corporation Act, and whose mission emphasizes natural resource conservation or supports science-based natural resource management. A local or state chapter or division of a national or international conservation organization shall qualify as a conservation organization. A person who purchases a deer license from a conservation organization under these rules is not subject to the restriction provided in 12.5(1)“b.”

“Coordinator” means the department staff person appointed by the director to administer the process for allocation of special nonresident deer and turkey licenses pursuant to this chapter.

“Department” means the department of natural resources.

“Director” means the director of the department of natural resources.

“Internal committee” means the committee that ranks certain requests for special licenses for consideration by the director or the director’s designee and consists of the coordinator, the administrator of the conservation and recreation division, the chief of the wildlife bureau, and the chief of the law enforcement bureau.

“Nonresident disabled veteran or disabled member of the armed forces” means a person who is a veteran and who has an assigned service-related disability rating of 30 percent or more under United States Code, Title 38, Chapter 11; or a person who is a member of the armed forces serving on active federal duty currently participating in the Integrated Disability Evaluation System (IDES).

“Outdoor industry” means a commercial enterprise or venture that promotes or otherwise contributes to the use of natural resources. For purposes of illustration, an outdoor industry may include, but is not limited to, a television or radio show production; a video/DVD production; still and motion photography; an article in the popular print media, such as in a newspaper or periodical; a lecture presentation; the manufacture or acquisition of sporting equipment for resale; or a similar activity. A business that solely provides guide or outfitter services is not an outdoor industry.

“Program” means the review and selection process through which special nonresident deer and turkey licenses are allocated in accordance with Iowa Code section 483A.24 and these rules.

“Special licenses” means the special nonresident deer licenses and special nonresident turkey licenses issued pursuant to these rules.

“Special nonresident deer license” means a deer license issued pursuant to Iowa Code section 483A.24(3).

“Special nonresident turkey license” means a turkey license issued pursuant to Iowa Code section 483A.24(4).

“Sponsor” means an entity that applies on behalf of one or more hunters. Sponsors shall either conduct business in Iowa and be registered with the secretary of state or have some other affiliation with the state of Iowa.

[ARC 7814B, IAB 6/3/09, effective 7/8/09; ARC 8753B, IAB 5/19/10, effective 6/23/10; ARC 2379C, IAB 2/3/16, effective 3/9/16; ARC 5517C, IAB 3/10/21, effective 4/14/21]

561—12.3(483A) Availability of special licenses. The program shall be available to provide no more than the number of special licenses allowed by Iowa Code section 483A.24 to nonresidents through requests submitted by individual hunters, through a sponsor, or through an approved organization.
[ARC 7814B, IAB 6/3/09, effective 7/8/09; ARC 8753B, IAB 5/19/10, effective 6/23/10; ARC 2379C, IAB 2/3/16, effective 3/9/16]

561—12.4(483A) Coordinator duties. The coordinator of the program shall:

12.4(1) Assist the internal committee in the evaluation and selection of hunters who may receive special licenses.

12.4(2) Develop templates for requests for special licenses and provide the templates to hunters, sponsors, and approved organizations upon request.

12.4(3) Convene the internal committee to rank hunters according to the criteria in rule 561—12.7(483A).

12.4(4) Summarize each request received and distribute the summaries to the internal committee and the director or the director's designee.

12.4(5) Establish the date on which applications for special licenses for disabled veterans and disabled active military personnel are due, establish the dates on which the director or the director's designee will select the conservation organizations and hunters who will receive special licenses, and inform the conservation organizations, the approved organizations and the hunters of their selection.
[ARC 7814B, IAB 6/3/09, effective 7/8/09; ARC 2379C, IAB 2/3/16, effective 3/9/16; ARC 5517C, IAB 3/10/21, effective 4/14/21]

561—12.5(483A) Request, review, and selection process for promotional special licenses.

12.5(1) *Submission of requests.*

a. Individual hunters or sponsors shall submit a request, or requests, to the coordinator.

(1) A request for a deer license must be on the form provided by the department and shall be submitted to the coordinator by August 15 prior to the season to be hunted.

(2) A request for a turkey license must be on the form provided by the department and shall be submitted to the coordinator at least 14 days prior to the season to be hunted.

b. Applicants will not qualify for a deer license under this rule if they were issued a deer license under this rule the previous year.

c. Hunters awarded a deer license under this rule may purchase preference points for the regular nonresident deer license and shall not lose those preference points when awarded a deer license under this rule.

12.5(2) *Review.* The internal committee shall review the summaries prepared by the coordinator, rank the hunters according to criteria in rule 561—12.7(483A), and forward the rankings to the director or the director's designee for consideration and final selection. The internal committee shall exercise its discretion and, in addition to the criteria in rule 561—12.7(483A), shall also consider the following:

a. Requests that demonstrate little or no promotion of the state of Iowa or its natural resources shall not be included in the rankings forwarded to or considered by the director or the director's designee.

b. Requests from a sponsor, a sponsor-related entity, or hunter that has been found guilty of a game violation in Iowa or elsewhere within the past five years or that, in the opinion of the internal committee, has exhibited poor hunting ethics or judgment shall not be considered for a special license.

c. Review of requests shall occur at least once annually but may occur more frequently as needed based upon the number of requests and the dates by which they are received.

12.5(3) *Selection and payment.* Upon notice of selection to receive a special license, the sponsor or hunter shall make payment in accordance with rule 561—12.12(483A) to the department through the coordinator. Payment must be made at least 30 days prior to the hunting season for which the license is valid.

[ARC 7814B, IAB 6/3/09, effective 7/8/09; ARC 8753B, IAB 5/19/10, effective 6/23/10; ARC 2379C, IAB 2/3/16, effective 3/9/16; ARC 5517C, IAB 3/10/21, effective 4/14/21]

561—12.6(483A) Consideration of requests for promotional special licenses. The internal committee will recommend to the director or the director's designee which conservation organizations are best qualified to promote the state and its natural resources. In making recommendations to the director or

the director's designee, the internal committee will base its recommendations on the expected ability of hunters to promote the state and its natural resources and, if applicable, based on the degree of success special license holders have had in previous years or seasons in promoting the state and its natural resources. By way of illustration, the committee may consider requests from the following:

12.6(1) A hunter who has a direct beneficial impact on the state through an arm's-length business relationship with an Iowa-based outdoor industry.

12.6(2) A conservation organization that will use the special nonresident deer license as a fundraiser for that organization. A conservation organization shall be limited to one special nonresident deer license per year, whether the organization is a local or state chapter or division of a national or international conservation organization. The organization shall return to the department the greater amount of either one-half of the proceeds from its sale of the special nonresident deer license or the fee for a nonresident deer license as set forth in Iowa Code section 483A.1. The department's proceeds shall cover the cost of the special nonresident deer license. A license made available to a conservation organization in accordance with this subrule may be valid for up to two years after selection of the organization by the director or the director's designee. The sponsoring conservation organization shall notify the coordinator by July 1 or immediately following the sale of the special nonresident deer license of which year and for what season the special nonresident deer license will be used. The conservation organization shall specifically explain how and during what period the organization will market the special nonresident deer license for auction or some other legal fundraiser.

12.6(3) A hunter nominated by the governor or a member of the Iowa legislature.

12.6(4) A hunter recommended by the department.

12.6(5) A hunter who is a well-known public figure nationally or regionally and who may provide a positive portrayal of the state and its natural resources.

[ARC 7814B, IAB 6/3/09, effective 7/8/09; ARC 8753B, IAB 5/19/10, effective 6/23/10; ARC 2379C, IAB 2/3/16, effective 3/9/16; ARC 5517C, IAB 3/10/21, effective 4/14/21]

561—12.7(483A) Ranking criteria for promotional special licenses.

12.7(1) The following criteria shall be used by the internal committee to rank individual hunters as identified in subrules 12.6(1), 12.6(4) and 12.6(5). The rankings shall be determined as the average of the following rating points and will be provided to the director or the director's designee as an aid in determining the selection of hunters.

a. Five points if the hunter is directly affiliated with an Iowa-based outdoor industry.

b. From 0 to 10 points for the following:

(1) The relative size of the hunter's potential audience.

(2) The hunter's proposal to promote the state and its natural resources.

(3) If the hunter has received a special license in the past, the value of the actual promotion of the state and its natural resources or special services provided as a result.

c. From 0 to 5 points if the hunter meets the description in subrule 12.6(5).

12.7(2) A conservation organization's request shall be forwarded to the director or the director's designee if the conservation organization meets the definition in rule 561—12.2(483A) and approval shall be based on evaluation of the organization's prior performance, if any, in selling the special nonresident deer license.

12.7(3) Hunters as identified in subrule 12.6(3) shall not be ranked by the internal committee, and their requests will be forwarded to the director or the director's designee for consideration.

[ARC 7814B, IAB 6/3/09, effective 7/8/09; ARC 8753B, IAB 5/19/10, effective 6/23/10; ARC 2379C, IAB 2/3/16, effective 3/9/16; ARC 5517C, IAB 3/10/21, effective 4/14/21]

561—12.8(483A) Services provided by recipients of promotional special licenses. In addition to promoting the state and its natural resources, recipients of special licenses may improve the ranking they receive for future license requests by providing additional services as specified by the department. Services shall be limited to those that improve communications between the department and outdoor recreationalists and to assistance in marketing outdoor recreation and natural resource conservation.

[ARC 7814B, IAB 6/3/09, effective 7/8/09; ARC 8753B, IAB 5/19/10, effective 6/23/10; ARC 2379C, IAB 2/3/16, effective 3/9/16]

561—12.9(483A) License term for promotional special licenses. With the exception of the term provided for in subrule 12.6(2), special licenses issued under these rules shall be valid for only the applicable deer or turkey season immediately following allocation of the license.

[ARC 7814B, IAB 6/3/09, effective 7/8/09; ARC 2379C, IAB 2/3/16, effective 3/9/16]

561—12.10(483A) Reporting by recipients of promotional special licenses. Within eight months after a hunter's participation in a hunt with a license issued pursuant to this chapter, the sponsor or hunter shall provide to the coordinator information about the hunt to demonstrate how the hunt will provide or has provided promotion of the state and its natural resources. This information may be in the form of testimonials of the participants, a completed DVD available for retail sale, a DVD copy of the actual television broadcast, an article in a periodical, or other verifiable means that demonstrate the promotional benefits. The director or the director's designee may consider compliance with this reporting requirement in evaluating future requests.

[ARC 7814B, IAB 6/3/09, effective 7/8/09; ARC 2379C, IAB 2/3/16, effective 3/9/16; ARC 5517C, IAB 3/10/21, effective 4/14/21]

561—12.11(483A) Prohibitions for promotional special licenses. Photographs, videotapes, or any other form of media resulting from the special licenses issued pursuant to this chapter shall not be used for political campaign purposes.

[ARC 7814B, IAB 6/3/09, effective 7/8/09; ARC 2379C, IAB 2/3/16, effective 3/9/16]

561—12.12(483A) License costs for promotional special licenses. With the exception provided in subrule 12.6(2) for conservation organizations, a nonresident who obtains a special license issued pursuant to this chapter shall pay the applicable fee as follows:

12.12(1) For a special nonresident deer license, the fee described in Iowa Code section 483A.1 for a deer hunting license, antlered or any sex deer.

12.12(2) For a special nonresident turkey license, the fee described in Iowa Code section 483A.1 for a wild turkey hunting license.

[ARC 7814B, IAB 6/3/09, effective 7/8/09; ARC 2379C, IAB 2/3/16, effective 3/9/16]

561—12.13(483A) Hunter safety requirements for holders of promotional special licenses. As provided in Iowa Code sections 483A.24(3) and 483A.24(4), the hunter safety and ethics certificate requirement is waived for holders of special licenses issued pursuant to this chapter.

[ARC 7814B, IAB 6/3/09, effective 7/8/09; ARC 2379C, IAB 2/3/16, effective 3/9/16]

561—12.14(483A) Request, review, and selection processes for special licenses for nonresident disabled veterans or disabled members of the armed forces.

12.14(1) Submission of requests.

a. Individual hunters or approved organizations shall submit a request, or requests, to the coordinator.

(1) A request for a deer license must be on the form provided by the department and shall be submitted to the coordinator by August 1 prior to the season to be hunted.

(2) A request for a turkey license must be on the form provided by the department and shall be submitted to the coordinator at least 14 days prior to the season to be hunted.

(3) A request for a regular hunting license that includes the habitat fee must be on the form provided by the department and shall be submitted to the coordinator prior to the seasons to be hunted.

b. Applicants will not qualify for a deer or turkey license under this rule if they were issued a deer or turkey license under this rule the previous year. However, if there are unclaimed deer or turkey licenses under this rule, then the coordinator may keep a list of applicants who received licenses the previous year and who apply for the current year, and process those applicants' applications through an electronic, unbiased lottery system to determine the recipients of the unclaimed licenses.

c. Hunters awarded a deer license under this rule may purchase preference points for the regular nonresident deer license and shall not lose those preference points when awarded a deer license under this rule.

12.14(2) Review. After the established deadlines have passed, the coordinator shall review the applications for completeness and shall process the complete applications through an electronic, unbiased lottery system to determine the recipients of the special licenses. The coordinator shall exercise discretion and shall also consider the following:

a. Requests from an approved organization or hunter that has been found guilty of a game violation in Iowa or elsewhere shall not be considered for a special license.

b. If special licenses are unclaimed after the established deadlines, the coordinator may set new deadlines and inform participating approved organizations that licenses are still available. Applications shall be processed through an electronic, unbiased lottery system to determine the recipients.

12.14(3) Selection and payment. Upon notice of selection to receive a special license, the approved organization or hunter shall make payment in accordance with rule 561—12.17(483A) to the department through the coordinator. Payment must be made prior to the hunting season for which the license is valid. [ARC 2379C, IAB 2/3/16, effective 3/9/16]

561—12.15(483A) License term for disabled veteran and military special licenses. Special deer or turkey licenses issued under these rules shall be valid for only the applicable deer or turkey season immediately following allocation of the license. [ARC 2379C, IAB 2/3/16, effective 3/9/16]

561—12.16(483A) Prohibitions for disabled veteran and military special licenses. Photographs, videotapes or any other form of media resulting from the special licenses issued pursuant to this chapter shall not be used for political campaign purposes. [ARC 2379C, IAB 2/3/16, effective 3/9/16]

561—12.17(483A) License costs for disabled veteran and military special licenses. A nonresident who obtains a special license issued pursuant to this chapter shall pay the applicable fee as follows:

12.17(1) For a special nonresident deer hunting antlered or any sex deer license or a turkey hunting license, the fee described in Iowa Code section 483A.24(5)“c.”

12.17(2) For a special nonresident hunting license that includes the wildlife habitat fee, the fee described in Iowa Code section 483A.24(5)“d.” [ARC 2379C, IAB 2/3/16, effective 3/9/16]

561—12.18(483A) Hunter safety requirements for disabled veterans and military hunters. As provided in Iowa Code section 483A.24(5), a hunter education certificate is required for holders of special disabled veteran and military licenses issued pursuant to this chapter. [ARC 2379C, IAB 2/3/16, effective 3/9/16]

These rules are intended to implement Iowa Code section 483A.24.

[Filed ARC 7814B (Notice ARC 7652B, IAB 3/25/09), IAB 6/3/09, effective 7/8/09]

[Filed ARC 8753B (Notice ARC 8595B, IAB 3/10/10), IAB 5/19/10, effective 6/23/10]

[Filed ARC 2379C (Notice ARC 2132C, IAB 9/2/15), IAB 2/3/16, effective 3/9/16]

[Filed ARC 5517C (Notice ARC 5379C, IAB 1/13/21), IAB 3/10/21, effective 4/14/21]

CHAPTER 46
WITHHOLDING

[Prior to 12/17/86, Revenue Department[730]]

701—46.1(422) Who must withhold.

46.1(1) Requirement of withholding.

a. General rule. Every employer maintaining an office or transacting business within this state and required under provisions of Sections 3401 to 3404 of the Internal Revenue Code to withhold and pay federal income tax on compensation paid for services performed in this state to an individual is required to deduct and withhold from such compensation for each payroll period (as defined in Section 3401(b) of the Internal Revenue Code) an amount computed in accordance with subrules 46.2(1) and 46.2(2). Iowa income tax is not required to be withheld on any compensation paid in this state of a character which is not subject to federal income tax withholding (whether or not such compensation is subject to withholding for federal taxes other than income tax, e.g., FICA taxes), except as provided in rule 701—46.4(422).

b. Examples. Paragraph “a” above may be illustrated by the following examples:

(1) Temporary help. A is a typist in the offices of B corporation, where she has worked regularly for two months. A is, however, supplied to B corporation by C, a temporary help agency located in Iowa. C renders a weekly bill to B corporation for A’s services, and C then pays A. B corporation is not A’s “employer” within Section 3401(d) of the Internal Revenue Code, and B corporation is therefore not required by the Internal Revenue Code to withhold a tax on A’s compensation. Since B corporation is not required to withhold a tax for federal purposes on A’s compensation, B is not required to do so for Iowa purposes. C, the temporary help agency, however, is required to withhold from A’s compensation for federal purposes and must also do so for Iowa purposes.

(2) Domestic help. A is employed as a cook by Mr. and Mrs. B. The B’s are required to withhold FICA (i.e., Social Security) tax from compensation paid to A, but are not required to withhold income tax from such compensation under the Internal Revenue Code, because under Section 3401(a)(3), A’s compensation does not constitute “wages”. Since the B’s are not required to withhold income tax for federal purposes, they are not required to do so for Iowa purposes.

(3) Executives. A is a corporate executive. On January 1, 1998, A entered into an agreement with B corporation under which he was to be employed by B in an executive capacity for a period of five years. Under the contract, A is entitled to a stated annual salary and to additional compensation of \$10,000 for each year. The additional compensation is to be credited to a bookkeeping reserve account and deferred, accumulated and paid in annual installments of \$5,000 on A’s retirement beginning January 1, 2003. In the event of A’s death prior to exhaustion of the account, the balance is to be paid to A’s personal representative. A is not required to render any service to B after December 31, 2002. During 2003, A is paid \$5,000 while a resident of Iowa. The \$5,000 is not excluded from “wages” under Section 3401(a) of the Internal Revenue Code; therefore, B is required to withhold federal income tax, and, since it is compensation paid in this state, B must withhold Iowa income tax on A’s deferred compensation.

(4) Agricultural labor. Wages paid for agricultural labor are subject to withholding for state income tax purposes to the same extent that the wages are subject to withholding for federal income tax purposes.

c. Exemption from withholding. An employer may be relieved of the responsibility to withhold Iowa income tax on an employee who does not anticipate an Iowa income tax liability for the current tax year.

An employee who anticipates no Iowa income tax liability for the current tax year shall file with the employer a withholding allowance certificate claiming exemption from withholding. An employee who meets this criterion may claim an exemption from withholding at any time; however, this exemption from withholding must be renewed by February 15 of each tax year that the criterion is met. If the employee wishes to discontinue or is required to revoke the exemption from withholding, the employee must file a new withholding allowance certificate within ten days from the date the employee anticipates a tax liability or on or before December 31 if a tax liability is anticipated for the next tax year. See subrule 46.3(2).

d. Withholding from lottery winnings. Every person, including employees and agents of the Iowa lottery authority, making any payment of “winnings subject to withholding” shall deduct and withhold a tax in an amount equal to 5 percent of the winnings. The tax shall be deducted and withheld upon payment of the winnings to a payee by the person or payer making this payment. Any person or payee receiving a payment of winnings subject to withholding must furnish the payer with a statement as is required under Treasury Regulation §31.3402(q)-1, paragraph “e,” with the information required by that paragraph. Payers of winnings subject to withholding must file Form W-2G with the Internal Revenue Service, the department of revenue, and the payee of the lottery winnings by the dates specified in the Internal Revenue Code and in Iowa Code section 422.16. The W-2G form shall include the information described in Treasury Regulation §31.3402(q)-1, paragraph “f.”

“Winnings subject to withholding” means any payment where the proceeds from a wager exceed \$600. The rules for determining the amount of proceeds from a wager under Treasury Regulation Section 31.3402(q)-1, paragraph “c,” shall apply when determining whether the proceeds from Iowa lottery winnings are great enough so that withholding is required. This rule shall apply to winnings from tickets purchased from the Powerball and Hot Lotto games or any other similar games to the extent the tickets were purchased within the state of Iowa.

e. Withholding from prizes from games of skill, games of chance, or raffles. Every person making any payment of a “prize subject to withholding” must deduct and withhold a tax in an amount equal to 5 percent of the prize from a game of skill, a game of chance, or a raffle. Effective July 1, 2015, any person making any payment of a “prize subject to withholding” for bingo must withhold tax in the same manner as persons making payments of prizes subject to withholding for games of skill, games of chance, or raffles. The tax must be deducted and withheld upon payment of the winnings to a payee by the person making this payment. Any person or payee receiving a payment of winnings subject to withholding must furnish the payer with a statement as is required under Treasury Regulation Section 31.3402(q)-1, paragraph “e,” with the information required by that paragraph. Payers of prizes subject to withholding must file Form W-2G with the Internal Revenue Service, the department of revenue, and the payee of the prize by the dates specified in the Internal Revenue Code and in Iowa Code section 422.16. The W-2G form must include the information described in Treasury Regulation Section 31.3402(q)-1, paragraph “f.”

“Prizes subject to withholding” means any payment of a prize where the amount won exceeds \$600.

f. Withholding from winnings from pari-mutuel wagers. Every person making any payment of “winnings subject to withholding” must deduct and withhold a tax in an amount equal to 5 percent of the winnings from pari-mutuel wagers. The tax must be deducted and withheld upon payment of the winnings to a payee by the person making this payment. Any person or payee receiving a payment of winnings subject to withholding must furnish the payer with a statement as is required under Treasury Regulation Section 31.3402(q)-1, paragraph “e,” with the information required by that paragraph. Payers of winnings subject to withholding must file Form W-2G with the Internal Revenue Service, the department of revenue, and the payee of the winnings by the dates specified in the Internal Revenue Code and in Iowa Code section 422.16. The W-2G form must include the information described in Treasury Regulation Section 31.3402(q)-1, paragraph “f.”

“Winnings subject to withholding” are winnings in excess of \$1,000.

g. Withholding from winnings from slot machines on riverboat gambling vessels and from winnings from slot machines at racetracks. Withholding of state income tax is required if the winnings from slot machines on riverboat gambling vessels or from slot machines at racetracks exceed \$1,200.

46.1(2) *Withholding on pensions, annuities and other nonwage payments to Iowa residents.* State income tax is required to be withheld from payments of pensions, annuities, supplemental unemployment benefits and sick pay benefits and other nonwage income payments made to Iowa residents in those circumstances mentioned in the following paragraphs. This subrule covers those nonwage payments described in Sections 3402(o), 3402(p), 3402(s), 3405(a), 3405(b), and 3405(c) of the Internal Revenue Code. This includes, but is not limited to, payments from profit-sharing plans, stock bonus plans, deferred compensation plans, individual retirement accounts, lump-sum distributions from qualified retirement plans, other retirement plans, and annuities, endowments and life insurance contracts issued by life

insurance companies. These payments are subject to Iowa withholding tax if they are also subject to federal withholding tax. However, no state income tax withholding is required from nonwage payments to residents to the extent those payments are not subject to state income tax. See paragraph 46.1(2) "h" for threshold amounts for withholding from payments of pensions, annuities, individual retirement accounts, deferred compensation plans, and other retirement incomes which are made on or after January 1, 2001. In the case of some nonwage payments to residents, such as payments of pensions and annuities, no state income tax is required to be withheld if no federal income tax is being withheld from the payments of the pensions and annuities. The rate of withholding on the nonwage payments described in this subrule is 5 percent of the payment amounts or 5 percent of the taxable amounts unless specified otherwise.

For purposes of this subrule, an individual receiving nonwage payments will be considered to be an Iowa resident and subject to this subrule if the individual's permanent residence is in Iowa. The fact that a nonwage payment is deposited in a recipient's account in a financial institution located outside Iowa does not mean that the recipient's permanent residence is established in the place where the financial institution is situated.

Payers of pension and annuity benefits and other nonwage payments have the option of either withholding Iowa income tax from these payments on the basis of tables and formulas included in the Iowa withholding tax guide of the department of revenue or withholding Iowa income tax from these payments at the rate of 5 percent. State income tax is required to be withheld by payers in situations when federal income tax is being withheld from the nonwage payments.

a. Withholding from pension and annuity payments to residents. Withholding of state income tax is required from payments of pensions and annuities to Iowa residents to the extent that the recipients of the payments have not filed with the payers of the benefits election forms which specify that no federal income tax is to be withheld. Therefore, state income tax is to be withheld when federal income tax is being withheld from the pensions or annuities. See paragraph 46.1(2) "h" for threshold amounts for withholding from payments of pensions, annuities, and other retirement incomes which are made on or after January 1, 2001.

However, although Iowa income tax is ordinarily required to be withheld from pension and annuity payments made to Iowa residents if federal income tax is being withheld from the payments, no state income tax is required to be withheld if pension and annuity payments are not subject to Iowa income tax, as in the case of railroad retirement benefits which are exempt from Iowa income tax by a provision of federal law.

b. Withholding from payments to residents from profit-sharing plans, stock bonus plans, deferred compensation plans, individual retirement accounts and from annuities, endowments and life insurance contracts issued by life insurance companies. Payments to Iowa residents from profit-sharing plans, stock bonus plans, deferred compensation plans, individual retirement accounts and payments from life insurance companies for contracts for annuities, endowments or life insurance benefits are subject to withholding of state income tax if federal income tax is withheld from the benefits. However, no state income tax is to be withheld from the income tax payments described above to the extent those income tax payments are exempt from Iowa income tax. See paragraph 46.1(2) "h" for thresholds for withholding from payments of pensions, annuities, individual retirement accounts, deferred compensation plans, and other retirement incomes which are made on or after January 1, 2001.

In cases where the recipients elect withholding of state income tax from the income payments, the payers are to withhold from the payments at a rate of 5 percent on the taxable portion of the payment, if that can be determined by the payer or on the entire income payment if the payer does not know how much of the payment is taxable. Once a recipient makes an election for state income tax withholding, that election will remain in effect until a later election is made.

c. Withholding from payments to residents for supplemental unemployment compensation benefits and sick pay benefits. Income payments made for supplemental unemployment compensation benefits described in Section 3402(o)(2)(a) of the Internal Revenue Code and for sick pay benefits are subject to withholding of state income tax. In the case of supplemental unemployment compensation benefits, those benefits are treated as wages for purposes of state income tax withholding. Therefore, state income tax should be withheld from these payments when federal income tax is withheld. The amount of state

income tax withholding should be determined by the withholding tables provided in the Iowa employers' "Withholding Tax Guide."

In the case of state income tax withholding for sick pay benefits paid by third-party payers in accordance with Section 3402(o)(1) of the Internal Revenue Code, state income tax is to be withheld from the benefits by the payer only if state income tax withholding is requested by the payee of the benefits. However, payees of sick pay benefits should probably not request withholding from the benefits if the payees are eligible for the disability income exclusion authorized in Iowa Code section 422.7 and described in rule 701—40.22(422). If withholding is requested by the payee, the withholding should be done at a 5 percent rate on the sick pay benefits. Once withholding is started, it should continue until such time as the payee requests that no state income tax be withheld. For sick pay benefits not paid by third-party payers, state income tax is required to be withheld since federal income tax is required to be withheld.

d. Voluntary state income tax withholding from unemployment benefit payments. Recipients of unemployment benefit payments described in Section 3402(p)(2) of the Internal Revenue Code may elect to have state income tax withheld from the benefit payments at a rate of 5 percent. An individual's election to have state income tax withheld from unemployment benefits is separate from any election to have federal income tax withheld from the benefits.

e. Withholding on lump-sum distributions from qualified retirement plans. For lump-sum distribution payments from qualified retirement plans made to Iowa residents, state income tax is required to be withheld under the conditions described in this paragraph. No state income tax is required to be withheld from a lump-sum distribution payment to an Iowa resident in a situation where the payment is not subject to Iowa income tax. See paragraph 46.1(2) "h" for thresholds for withholding on lump-sum distributions issued on or after January 1, 2001. Iowa income tax is to be withheld from a lump-sum distribution made to an Iowa resident to the extent that federal income tax is being withheld from the distribution. The rate of withholding of state income tax from the lump-sum distribution is 5 percent from the total distribution or 5 percent from the taxable amount if that amount is known by the payer. Note that in the case of a lump-sum distribution, the Iowa income tax imposed on the taxable amount of the distribution is 25 percent of the federal income tax on the distribution.

f. Withholding of state income tax from nonwage payments to residents on the basis of tax tables and tax formulas. State income tax from the nonwage payments made to Iowa residents may be withheld on the basis of formulas and tables included in the Iowa withholding tax guide of the department of revenue. See paragraph 46.1(2) "h" for threshold amounts for withholding from payments of pensions, annuities, individual retirement accounts, deferred compensation plans, and other retirement incomes which are made on or after January 1, 2001. When state income tax is being withheld based upon the formulas or tables in the withholding guide, the amounts of the nonwage payments are treated as wage payments for purposes of the tables or the formulas.

The frequency of the nonwage payments determines which of the withholding tables to use or the number of pay periods in the calendar year to use in the formula. For example, if the nonwage payment is made on a monthly basis, the monthly wage bracket withholding table should be utilized for withholding or 12 should be utilized in the formula to indicate that there will be 12 nonwage payments in the year.

The payers of nonwage payments should withhold state income tax from the nonwage payments to Iowa residents when federal income tax is being withheld from the nonwage payments. The payers should withhold from the nonwage payments to Iowa residents from tables or the formulas in the Iowa withholding guide on the basis of the number of withholding exemptions claimed on Form IA W-4 which has been completed by the payees of the payments. However, if a payee of a nonwage payment has not completed an IA W-4 form (Iowa employee's withholding allowance certificate) by the time a nonwage payment is to be made by the payer of the nonwage payment, the payer is to withhold state income tax on the basis that the payee has claimed one withholding allowance or exemption.

In a situation when a payee of a nonwage payment completes Form IA W-4 and claims exemption from state income tax withholding when federal income tax is being withheld from the nonwage payment, the payer of the nonwage payment should withhold state income tax using one withholding allowance or exemption unless the payee has verified exemption from state income tax.

g. Withholding on distributions from qualified retirement plans that are not directly rolled over. State income tax is to be withheld at a rate of 5 percent from the gross amount or taxable amount if known by the payer of the distribution made to Iowa residents if the distributions are not transferred directly to an IRA, Section 403(a) annuity or another qualified retirement plan. The distributions that are subject to state income tax withholding are those distributions that are subject to 20 percent withholding for federal income tax purposes. See paragraph 46.1(2) “h” for thresholds for withholding from payments of pensions, annuities, individual retirement accounts, deferred compensation plans, and other retirement plans which are made on or after January 1, 2001.

h. Withholding from distributions made on or after January 1, 2001, from pensions, annuities, individual retirement accounts, deferred compensation plans, and other retirement plans. Effective for distributions made on or after January 1, 2001, from pension plans, annuities, individual retirement accounts, deferred compensation plans, and other retirement plans, state income tax is generally required to be withheld from the distributions when federal income tax is being withheld from the distributions, unless one of the exceptions for withholding in this paragraph applies. For purposes of this paragraph, the term “pensions and other retirement plans” includes all distributions of retirement benefits covered by the partial exemption described in rule 701—40.47(422).

State income tax is not required to be withheld from a distribution from a pension or other retirement plan if the distribution is an income which is not subject to Iowa income tax, such as a distribution of railroad retirement benefits. State income tax is also not required to be withheld from a pension plan or other retirement plan if the amount of the distribution is \$500 per month or less or if the taxable amount is \$500 or less and the person receiving the distribution is eligible for the partial exemption of retirement benefits described in rule 701—40.47(422), if the state taxable amount can be determined by the payee of the distribution. There is also no requirement for withholding state income tax from a pension or other retirement plan if the distribution is \$1,000 per month or less or if the taxable amount is \$1,000 or less and the person receiving the distribution is eligible for the partial exemption of retirement benefits described in rule 701—40.47(422) and that person has indicated an intention to file a joint state income tax return for the year in which the distribution is made. In instances where the distribution amount or the taxable amount is more than \$500 per month but less than \$6,000 for the year, no state income tax will be required to be withheld, if the person receiving the distribution is eligible for the partial exemption of retirement benefits.

Finally, there is no requirement for withholding from a lump-sum payment from a qualified retirement plan if the lump-sum payment is \$6,000 or less, the recipient is eligible for the partial exemption of distributions from pensions and other retirement plans, and the lump-sum payment is the only distribution from the retirement plan in the year.

46.1(3) *Voluntary state income tax withholding from unemployment benefit payments.* Rescinded IAB 3/2/05, effective 4/6/05.

This rule is intended to implement Iowa Code sections 96.3, 99B.21, 99D.16, 99E.19, 99F.18, 422.5, 422.7, and 422.16.

[ARC 8589B, IAB 3/10/10, effective 4/14/10; ARC 1303C, IAB 2/5/14, effective 3/12/14; ARC 2512C, IAB 4/27/16, effective 6/1/16]

701—46.2(422) Computation of amount withheld.

46.2(1) Amount withheld.

a. General rules. Every employer required to deduct and withhold a tax on compensation paid in Iowa to an individual shall deduct and withhold for each payroll period an amount the total of which will approximate the employee’s annual tax liability. “Payroll period” for Iowa withholding purposes shall have the same definition as in Section 3401 of the Internal Revenue Code and shall include “miscellaneous payroll period” as that term is defined and used in that section and the associated regulations.

b. Methods of computations. Employers required to withhold Iowa income tax on compensation paid in this state shall compute the amount of tax to be withheld for each payroll period pursuant to the methods and rules provided herein.

(1) Tables. An employer may elect to use the withholding tables provided in the Iowa employers' withholding tax guide and withholding tables, which are available from the department of revenue.

(2) Formulas. Formulas that are provided in the Iowa employers' withholding tax guide and tax tables are available for employers who have a computerized payroll system.

(3) Other methods. An employer may request and be granted the use of an alternate method for computing the amount of Iowa tax to be deducted and withheld for each payroll period so long as the alternate proposal approximates the employee's annual Iowa tax liability. When submitting an alternate formula, the withholding agent should explain the formula and show examples comparing the amount of withholding under the proposed formula with the department's tables or computer formula at various income levels and by using various numbers of personal exemptions. Any alternate formula must be approved by the department prior to its use.

c. Supplemental wage payments. A supplemental wage payment is the payment of a bonus, commission, overtime pay, or other special payment that is made in addition to the employee's regular wage payment in a payroll period. When such supplemental wages are paid, the amount of tax required to be withheld shall be determined by using the current withholding tables or formulas. If supplemental wages are paid at the same time as regular wages, the regular tables or formulas are used in determining the amount of tax to be withheld as if the total of the supplemental and regular wages were a single wage payment for the regular payroll period. If supplemental wages are paid at any other time, the regular tables or formulas are used in determining the amount of tax to be withheld as if the supplemental wage were a single wage payment for the regular payroll period. When a withholding agent makes a payment of supplemental wages to an employee and the employer withholds federal income tax on a flat-rate basis, pursuant to Treasury Regulation §31.3402(g)-1, state income tax shall be withheld from the supplemental wages at a rate of 6 percent without consideration for any withholding allowances or exemptions.

d. Vacation pay. Amounts of so-called "vacation allowances" shall be subject to withholding as though they were regular wage payments made for the period covered by the vacation. If the vacation allowance is paid in addition to the regular wage payment for such period, the allowance shall be treated as supplemental wage payments.

46.2(2) Correction of underwithholding or overwithholding.

a. Underwithholding. If an employer erroneously underwithholds an amount of Iowa income tax required to be deducted and withheld from compensation paid to an employee within a payroll period, the employer should correct the error within the same calendar year by deducting the difference between the amount withheld and the amount required to be withheld from any compensation still owed the employee, even though such compensation may not be subject to withholding. If the error is discovered in a subsequent calendar year, no correction shall be made by the employer.

b. Overwithholding. If an employer erroneously overwithholds an amount of tax required to be deducted and withheld from compensation paid to an employee, repayment of such overwithheld amount shall be made in the same calendar year. Repayment may be made in either of two ways: (1) the amount of overwithholding may be repaid directly to the employee, in which case the employer must obtain written receipt showing the date and amount of the repayment, or (2) the employer may reimburse the employee by applying the overcollection against the tax required to be deducted and withheld on compensation to be paid in the same calendar year in which the overcollection occurred. If the error is discovered in a subsequent calendar year, no repayment shall be made.

c. Cross-reference. Rescinded IAB 3/2/05, effective 4/6/05.

46.2(3) Withholding on supplemental wage payments. Rescinded IAB 3/2/05, effective 4/6/05.

This rule is intended to implement Iowa Code section 422.16.

701—46.3(422) Forms, returns and reports.

46.3(1) Employer registration. Every employer or payer required to deduct and withhold Iowa income tax must register with the department of revenue by filing an "Iowa Business Tax Registration Form." The form shall indicate the employer's or payer's federal identification number. If an employer or payer has not received a federal employer's identification number, the department will issue a

temporary identification number. The employer or payer must notify the department when the federal employer identification number is assigned.

When initial payment of wages subject to Iowa withholding tax occurs late in the calendar quarter, or before the employer's or payer's federal employer's identification number is assigned by the Internal Revenue Service, the Iowa business tax registration form shall be forwarded along with the first quarterly withholding return. The responsible party(ies) shall be listed on the form.

If an employer deducts and withholds Iowa income tax but does not file the Iowa business tax registration form, the department may register the employer using the best information available. If an employer uses a service provider to report and remit Iowa withholding tax on behalf of the employer, the department may use information obtained from the service provider to register the employer if an Iowa business tax registration form is not filed. This information would include, but is not limited to, the name, address, federal employer's identification number, filing frequency, withholding agent and responsible party(ies) of the employer.

46.3(2) Allowance certificate.

a. General rules. On or before the date on which an individual commences employment with an employer, the individual shall furnish the employer with a signed Iowa employee's withholding allowance certificate (IA W-4) indicating the number of withholding allowances which the individual claims, which in no event shall exceed the number to which the individual is entitled. The employer is required to request a withholding allowance certificate from each employee. If the employee fails to furnish a certificate, the employee shall be considered as claiming no withholding allowances. See subrule 46.3(4) for information on Form IA W-4P which is to be used by payers of pensions, annuities, deferred compensation, individual retirement accounts and other retirement incomes.

The employer must submit to the department of revenue a copy of a withholding allowance certificate received from an employee if:

- (1) The employee claimed more than a total of 22 withholding allowances, or
- (2) The employee is claiming an exemption from withholding and it is expected that the employee's wages from that employer will normally exceed \$200 per week.

Employers required to submit withholding certificates should use the following address:

Iowa Department of Revenue
Compliance Division
Examination Section
Hoover State Office Building
P.O. Box 10456
Des Moines, Iowa 50306

The department will notify the employer whether to honor the withholding certificate or to withhold as though the employee is claiming no withholding allowances.

b. Form and content. The "Iowa Employee's Withholding Allowance Certificate" (IA W-4) must be used to determine the number of allowances that may be claimed by an employee for Iowa income tax withholding purposes. Generally, the greater number of allowances an employee is entitled to claim, the lower the amount of Iowa income tax to be withheld for the employee. The following withholding allowances may be claimed on the IA W-4 form:

(1) Personal allowances. An employee can claim one personal allowance or two if the individual is eligible to claim head of household status. The employee can claim an additional allowance if the employee is 65 years of age or older and another additional allowance if the employee is blind.

If the employee is married and the spouse either does not work or is not claiming an allowance on a separate W-4 form, the employee can claim an allowance for the spouse. The employee may also claim an additional allowance if the spouse is 65 years of age or older and still another allowance if the spouse is blind.

(2) Dependent allowances. The employee can claim an allowance for each dependent that the employee will be able to claim on the employee's Iowa return.

(3) Allowances for itemized deductions. The employee can claim allowances for itemized deductions to the extent the total amount of estimated itemized deductions for the tax year for the

employee exceeds the applicable standard deduction amount by \$200. In instances where an employee is married and the employee's spouse is a wage-earner, the total allowances for itemized deductions for the employee and spouse should not exceed the aggregate amount itemized deduction allowances to which both taxpayers are entitled.

(4) Allowances for the child/dependent care credit. Employees who expect to be eligible for the child/dependent care credit for the tax year can claim withholding allowances for the credit. The allowances are determined from a chart included on the IA W-4 form on the basis of net income shown on the Iowa return for the employee. If the employee is married and has filed a joint federal return with a spouse who earns Iowa wages subject to withholding, the withholding allowances claimed by both spouses for the child/dependent care credit should not exceed the aggregate number of allowances to which both taxpayers are entitled. Taxpayers that expect to have a net income of \$45,000 or more for a tax year beginning on or after January 1, 2006, should not claim withholding allowances for the child and dependent care credit, since these taxpayers are not eligible for the credit.

(5) Allowances for adjustments to income. For tax years beginning on or after January 1, 2008, employees can claim allowances for adjustments to income which are set forth in Treasury Regulation §31.3402(m)-1, paragraph "b." This includes adjustments to income such as alimony, deductible IRA contributions, student loan interest and moving expenses which are allowed as deductions in computing income subject to Iowa income tax. In instances where an employee is married and the employee's spouse is a wage earner, the withholding allowances claimed by both spouses for adjustments to income for the employee and spouse should not exceed the aggregate number of allowances to which both taxpayers are entitled.

c. Change in allowances which affect the current calendar year.

(1) Decrease. If, on any day during the calendar year, the number of withholding allowances to which an employee is entitled is less than the number of withholding allowances claimed by the individual on a withholding certificate then in effect, the employee must furnish the employer with a new Iowa withholding allowance certificate relating to the number of withholding allowances which the employee then claims, which must in no event exceed the number to which the employee is entitled on such day.

(2) Increase. If, on any day during the calendar year, the number of withholding allowances to which an employee is entitled is more than the number of withholding allowances claimed by the employee on the withholding allowance certificate then in effect, the employee may furnish the employer with a new Iowa withholding allowance certificate on which the employee must in no event claim more than the number of withholding allowances to which the employee is entitled on such day.

d. Change in allowances which affect the next calendar year. If, on any day during the calendar year, the number of withholding allowances to which the employee will be, or may reasonably be expected to be, entitled to for the employee's taxable year which begins in, or with, the next calendar year is different from the number to which the employee is entitled on such day, the following rules shall apply:

(1) If such number is less than the number of withholding allowances claimed by an employee on an Iowa withholding allowance certificate in effect on such day, the employee must within a reasonable time furnish the employee's employer with a new withholding allowance certificate reflecting the decrease.

(2) If such number is greater than the number of withholding allowances claimed by the employee on an Iowa withholding allowance certificate in effect on such day, the employee may furnish the employee's employer with a new withholding allowance certificate reflecting the increase.

e. Duration of allowance certificate. An Iowa withholding allowance certificate which is in effect pursuant to these regulations shall continue in effect until another withholding allowance certificate takes effect. Employers should retain copies of the IA W-4 forms for at least four years.

46.3(3) Reports and payments of income tax withheld.

a. Returns of income tax withheld from wages.

(1) Quarterly returns. Every withholding agent required to withhold tax on compensation paid for personal services in Iowa shall make a return for the first calendar quarter in which tax is withheld and for each subsequent calendar quarter, whether or not compensation is paid therein, until a final return

is filed. The withholding agent's "Quarterly Withholding Return is the form prescribed for making the return required under this paragraph. Monthly tax deposits or semimonthly tax deposits may be required in addition to quarterly returns. See subparagraphs (2) and (3) of paragraph 46.3(3)"a." In some circumstances, only an annual return and payment of withheld taxes will be required; see paragraph 46.3(3)"c."

Payments shall be based upon the tax required to be withheld and must be remitted in full.

A withholding agent is not required to list the name(s) of the agent's employee(s) when filing quarterly returns, nor is the withholding agent required to show on the employee's paycheck or voucher the amount of Iowa income tax withheld.

If a withholding agent's payroll is not constant, and the agent finds that no wages or other compensation was paid during the current quarter, the agent shall enter the numeral "zero" on the return and submit the return as usual.

(2) Monthly deposits. Every withholding agent required to file a quarterly withholding return shall also file a monthly deposit if the amount of tax withheld during any calendar month exceeds \$500, but is less than \$10,000. A withholding agent needs to file a monthly deposit even if no payment is due. No monthly deposit is required for the third month in any calendar quarter. The information otherwise required to be reported on the monthly deposit for the third month in a calendar quarter shall be reported on the quarterly return filed for that quarter, and no monthly deposit need be filed for such month.

(3) Semimonthly deposits. Every withholding agent who withholds more than \$5,000 in a semimonthly period must file a semimonthly tax deposit. A semimonthly period is defined as the period from the first day of a calendar month through the fifteenth day of a calendar month, or the period from the sixteenth day of a calendar month through the last day of a calendar month. When semimonthly deposits are required, a withholding agent must still file a quarterly return.

(4) Final returns. A withholding agent who in any return period permanently ceases doing business shall file the returns required by subparagraphs (1), (2) and (3) of paragraph 46.3(3)"a" as final returns for such period. The withholding agent shall cancel the withholding tax registration by notifying the department.

b. Time for filing returns.

(1) Quarterly returns. Each return required by subparagraph 46.3(3)"a"(1) shall be filed on or before the last day of the first calendar month following the calendar quarter for which such return is made.

(2) Monthly tax deposits. Monthly deposits required by subparagraph 46.3(3)"a"(2) shall be filed on or before the fifteenth day of the second and third months of each calendar quarter for the first and second months of each calendar quarter, respectively.

(3) Semimonthly tax deposits. Semimonthly deposits required by subparagraph 46.3(3)"a"(3) for the semimonthly period from the first day of the month through the fifteenth day of the month shall be filed with payment of the tax on or before the twenty-fifth day of the same month. The semimonthly deposits required by subparagraph 46.3(3)"a"(3) for the semimonthly period from the sixteenth day of the month through the last day of the month shall be filed with payment of the tax on or before the tenth day of the month following the month in which the tax is withheld.

For withholding that occurs on or after January 1, 2005, quarterly returns, amended returns, monthly deposits and semimonthly deposits shall be made electronically in a format and by means specified by the department of revenue. Tax payments are considered to have been made on the date that the tax is transmitted and released by the vendor to the department.

(4) Determination of filing status. Effective July 1, 2002, the department and the department of management have the authority to change filing thresholds by department rule. This paragraph sets forth the filing thresholds for each filer based on the amount withheld for withholding that occurs on or after January 1, 2003.

The following criteria will be used by the department to determine if a change in filing status is warranted.

<u>Filing Status</u>	<u>Threshold</u>	<u>Test Criteria</u>
Semimonthly	Greater than \$120,000 in annual withholding taxes (more than \$5,000 in a semimonthly period).	Tax remitted in 3 of most recent 4 quarters examined exceeds \$30,000.
Monthly	Between \$6,000 and \$120,000 in annual withholding taxes (more than \$500 in a monthly period).	Tax remitted in 3 of most recent 4 quarters examined exceeds \$1,500 per quarter.
Quarterly	Less than \$6,000 in annual withholding taxes.	Tax remitted in 3 of most recent 4 quarters examined is less than \$1,500 per quarter.
Annual	Less than 3 employees.	

When it is determined that a withholding agent's filing status is to be changed, the withholding agent shall be notified in writing. A withholding agent has the option of requesting, within 30 days of the department's notice of a change in filing frequency, that the withholding agent file more or less frequently than required by the department. To request filing on a less frequent basis than assigned by the department, the request must be in writing and submitted to the department. A withholding agent's written request to be allowed to file less frequently than the filing status assigned by the department will be reviewed by the department, and a written determination will be issued to the withholding agent who made the request.

A change in assigned filing status to file on a less frequent basis will be granted in only two instances:

- Incorrect historical data is used in the conversion. A business may meet the criteria based on the original filing data, but, upon investigation, the filing history may prove that the business does not meet the dollar criteria because of adjustments, amended returns, or requests for refunds.
- Data available may have been distorted by the fact that the data reflected an unusual pattern in tax collection. The factors causing such a distortion must be documented and approved by the department.

A withholding agent may also request to file more frequently than assigned by the department. This request may be made orally, in writing, in person, or by telephone.

The department and the department of management may perform review of filing thresholds every five years or as needed based on department discretion. Factors the departments will consider in determining if the filing thresholds need to be changed include, but are not limited to: tax rate changes, inflation, the need to maintain consistency with required multistate compacts, changes in law, and migration between filing brackets.

c. Reporting annual withholding.

(1) Any withholding agent who does not have employee withholding but who is required to withhold state income tax from other distributions is exempted from the provisions of subparagraphs (2) and (3) of paragraph 46.3(3) "a," if these distributions are made annually in one calendar quarter. These withholding agents need only comply with the reporting requirements of the one calendar quarter in which the tax is withheld, and make the required year-end reports.

(2) Every withholding agent employing not more than two individuals and who expects to employ either or both for the full calendar year may pay with the withholding tax return due for the first calendar quarter of the year the full amount of income taxes which would be required to be withheld from the wages for the full calendar year. The withholding agent shall advise the department of revenue that annual reporting is contemplated and shall also state the number of persons employed. The withholding agent shall compute the annual withholding from wages by determining the normal withholding for one pay period and multiply this amount by the total number of pay periods within the calendar year. The withholding agent shall be entitled to recover from the employee(s) any part of such lump-sum payment that represents an advance to the employee(s). If a withholding agent pays a lump sum with the first quarterly return, the agent shall be excused from filing further quarterly returns for the calendar year

involved unless the agent hires other or additional employees. The “Verified Summary of Payments Report” shall be filed at the end of the tax year.

d. Reports for employee.

(1) General rule. Every employer required to deduct and withhold tax from compensation of an employee must furnish to each employee with respect to the compensation paid in Iowa by such employer during the calendar year, a statement containing the following information: the name, address, and federal employer identification number of the employer; the name, address, and social security number of the employee; the total amount of compensation paid in Iowa; and the total amount deducted and withheld as tax under subrule 46.1(1).

(2) Form of statement. The information required to be furnished to an employee under the preceding paragraph shall be furnished on an Internal Revenue Service combined Wage and Tax Statement, Form W-2, hereinafter referred to as “combined W-2.” Any reproduction, modification or substitution for a combined W-2 by the employer must be approved by the department. Employers should keep copies of the combined W-2 for four years from the end of the year for which the combined W-2 applies.

(3) Time for furnishing statement. Each statement required by paragraph “d” to be furnished for a calendar year and each corrected statement required for any prior year shall be furnished to the employee on or before January 31 of the year succeeding such calendar year, or if an employee’s employment is terminated before the close of a calendar year without expectation that it will resume during the same calendar year, within 30 days from the day on which the last payment of compensation is made, if requested by such employee, but not later than January 31 of the following year. See paragraph 46.3(3) “e” for provisions relating to the filing of copies of the combined W-2 with the department of revenue, and see subparagraph 46.3(3) “f”(1) for the provision relating to filing W-2 forms with the department for tax year 2019 and all subsequent tax years.

(4) Corrections. An employer must furnish a corrected combined W-2 to an employee if, after the original statement has been furnished, an error is discovered in either the amount of compensation shown to have been paid in Iowa for the prior year or the amount of tax shown to have been deducted and withheld in the prior year. Such statement shall be marked “corrected by the employer.” See paragraph 46.3(3) “e” for provisions relating to the filing of a corrected combined W-2 with the department.

(5) Undelivered combined W-2. Any employee’s copy of the combined W-2 which, after reasonable effort, cannot be delivered to an employee shall be transmitted to the department with a letter of explanation.

(6) Lost or destroyed. If the combined W-2 is lost or destroyed, the employer shall furnish a substitute copy to the employee. The copy shall be clearly marked “Reissued by Employer.”

e. Annual verified summary of payments reports.

(1) Every withholding agent required to withhold Iowa income tax under subrules 46.1(1), 46.1(2), and 46.4(1) is to furnish to the department of revenue on or before February 15 following the tax year an annual Verified Summary of Payments Report (VSP).

The withholding agent completing the VSP form must enter the total Iowa income tax withheld that is shown on the W-2 forms and 1099 forms for the year, the new jobs credits, supplemental new jobs credits, accelerated career education credits and targeted jobs credits claimed on withholding returns for the year. In addition, the withholding agent must enter on the VSP the withholding payments made for the year. If the amount of Iowa income tax withholding remitted to the department of revenue for the year is less than the withholding tax and withholding credits claimed, the withholding agent is to report the additional withholding tax due on an amended return and submit payment to the department.

If the Iowa income tax shown as withheld on the W-2 forms and 1099 forms issued for the tax year is less than the amount of withholding tax remitted to the department of revenue by the withholding agent, the agent should file an amended return with the department reflecting the excess tax paid.

(2) For VSP forms filed with the department of revenue for the year 2000 through the year 2016, the withholding agents are not to submit W-2 forms and 1099 forms with the reports. However, the withholding agents should supply W-2 forms or 1099 forms as requested by personnel of the department of revenue if the request for the forms is made within three years from the end of the year for which the

W-2 forms or 1099 forms apply. Therefore, if a request is made to a withholding agent for a W-2 form or a 1099 form for the year 2013, the request is valid if the request is postmarked, faxed or made on or before December 31, 2016.

(3) Penalty. Failure to meet the filing requirements set out in this paragraph will subject withholding agents to the penalties under Iowa Code section 422.16(10).

f. W-2 forms.

(1) For tax year 2019 and all subsequent tax years, all withholding agents are required to electronically file W-2 forms for employees from whom Iowa income tax was withheld with the department of revenue on or before February 15 following the tax year.

(2) The department of revenue may, in a case involving a hardship, extend the requirement to electronically file to the 2020 tax year. No extension of time shall be granted unless the withholding agent makes a written request to the department of revenue for such action.

(3) Penalty. Failure to meet the filing requirements set out in this paragraph will subject withholding agents to the penalties under Iowa Code section 422.16(10).

g. 1099 forms and W-2G forms.

(1) For tax year 2019 and all subsequent tax years, all withholding agents are required to electronically file all 1099 forms and W-2G forms for persons from whom Iowa income tax was withheld on or before February 15 following the tax year.

(2) The department of revenue may, in a case involving a hardship, extend the requirement to electronically file to the 2020 tax year. No extension of time shall be granted unless the withholding agent makes a written request to the department of revenue for such action.

(3) Penalty. Failure to meet the filing requirements set out in this paragraph will subject withholding agents to the penalties under Iowa Code section 422.16(10).

h. Withholding deemed to be held in trust. Funds withheld from wages for Iowa income tax purposes are deemed to be held in trust for payment to the department of revenue. The state and the department shall have a lien upon all the assets of the employer and all the property used in the conduct of the employer's business to secure the payment of the tax as withheld under the provisions of this rule. An owner, conditional vendor, or mortgagee of property subject to such lien may exempt the property from the lien granted to Iowa by requiring the employer to obtain a certificate from the department, certifying that such employer has posted with the department security for the payment of the amounts withheld under this rule.

i. Payment of tax deducted and withheld. The amount of tax shown to be due on each deposit or return required to be filed under subrule 46.3(3) shall be due on or before the date on which such deposit or return is required to be filed.

j. Correction of underpayment or overpayment of taxes withheld.

(1) Underpayment. If a return is filed for a return period under rule 701—46.3(422) and less than the correct amount of tax is reported on the return and paid to the department, the employer shall report and pay the additional amount due by filing an amended withholding tax return.

(2) Overpayment. If an employer remits more than the correct amount of tax for a return period, the employer must file an amended withholding tax return and request a refund of the withholding tax paid which was not due.

46.3(4) Iowa W-4P—withholding certificate for pension or annuity payments. For payments made from pension plans, annuity plans, individual retirement accounts, or deferred compensation plans to residents of Iowa, payers of these retirement benefits are to use Form IA W-4P for withholding of state income tax from the benefits. Generally, state income tax is required to be withheld from payments of distributions from the retirement incomes described above when federal income tax is being withheld from the payments. However, no state income tax is required to be withheld to the extent the monthly payment amount is \$500 or less or the taxable amount per month is \$500 or less if the payee is eligible for the retirement benefits exclusion described in rule 701—40.47(422). In addition, no state income tax is required to be withheld to the extent the monthly payment amount is \$1,000 or less or the taxable amount per month is \$1,000 or less if the payee is married and eligible for the retirement benefits exclusion described in rule 701—40.47(422).

Form IA W-4P is available from the department for payers of retirement benefits that intend to withhold at a rate of 5 percent from the payment amount or taxable payment amount after the \$6,000 to \$12,000 exclusion is considered. Note that the \$6,000 to \$12,000 exclusion is to be allocated to all retirement benefit payments made in the year and not just the first \$6,000 to \$12,000 in payments made in the year to an individual. If an individual receives retirement benefits and has not completed Form IA W-4P, the payer is directed to withhold Iowa income tax from the retirement benefit payment after a \$6,000 exclusion is allowed on an annual basis.

Payers of retirement benefits that want to use withholding formulas or tables to withhold state income tax instead of at the 5 percent rate may design their own IA W-4P withholding certificate form without approval of the department.

The payers are not responsible for improper choices made by a payee in completion of the IA W-4P. However, payers cannot accept a request for exemption from the withholding of state income tax made by a payee if federal income tax is being withheld unless the payee is eligible for exemption from withholding.

This rule is intended to implement Iowa Code sections 422.7 and 422.12C, and section 422.16 as amended by 2007 Iowa Acts, House File 904, section 3.

[ARC 8589B, IAB 3/10/10, effective 4/14/10; ARC 2739C, IAB 9/28/16, effective 11/2/16; ARC 3429C, IAB 10/25/17, effective 11/29/17; ARC 4678C, IAB 9/25/19, effective 10/30/19; ARC 5518C, IAB 3/10/21, effective 4/14/21]

701—46.4(422) Withholding on nonresidents.

46.4(1) General rules. Payers of Iowa income to nonresidents are required to withhold Iowa income tax and to remit the tax to the department on all payments of Iowa income to nonresidents except payments of wages to nonresidents engaged in film production or television production described in subrule 46.4(5); income payments for agricultural commodities or products described in subrule 46.4(6); deferred compensation payments, pension, and annuity payments attributable to personal services in Iowa by nonresidents described in subrule 46.4(7); and partnership distributions from certain publicly traded partnerships described in subrule 46.4(8). Withholding agents should use the following methods and rates in withholding for nonresidents:

a. Wages or salaries. Use the same withholding procedures, tables, formulas, and rates as are used for residents. See rule 701—46.2(422). Subrule 46.4(5) is an exception to the general rule. In addition, in accordance with the reciprocal tax agreement between Iowa and Illinois described in 701—subrule 38.13(1), Iowa withholding tax is not withheld on wages of Illinois residents who perform personal services in Iowa.

b. Payments other than wages, salaries, and other compensation for personal services. In lieu of using withholding tables or computer formulas to determine the amount of Iowa income tax to be withheld from payments made to nonresidents other than for salaries, wages, or other compensation for personal services, or income payments to nonresidents for agricultural commodities or products, Iowa income tax should be withheld at a rate of 5 percent of the amount of the payment. Subrule 46.4(6) describes the optional exemption from withholding of income payments made to nonresidents for the sale of agricultural commodities or products.

Nonresidents who prefer to make Iowa estimate payments instead of having Iowa income tax withheld from income payments from Iowa sources should refer to subrule 46.4(3) and rule 701—49.3(422).

46.4(2) Income of nonresidents subject to withholding. Listed below are various types of income paid to nonresidents which are subject to withholding tax. The list is for illustrative purposes only and is not deemed to be all-inclusive.

1. Personal service, including salaries, wages, commissions and fees for personal service wholly performed within this state and such portions of similar income of nonresident traveling salespersons or agents as may be derived from services rendered in this state.

2. Rents and royalties from real or personal property located within this state.

3. Interest or dividends derived from securities or investments within this state, when such interests or dividends constitute income of any business, trade, profession or occupation carried on within this state and subject to taxation.

4. Income derived from any business of a temporary nature carried on within this state by a nonresident, such as contracts for construction and similar contracts.

5. The distributive share of a nonresident beneficiary of an estate or trust, limited, however, to the portion thereof subject to Iowa income tax in the hands of the nonresident.

6. Income derived from sources within this state by attorneys, physicians, engineers, accountants, and similar sources as compensation for services rendered to clients in this state.

7. Compensation received by nonresident actors, singers, performers, entertainers, and wrestlers for performances in this state. See subrule 46.4(5) for an exception to this rule.

8. Income received by a nonresident partner or shareholder of a partnership or S corporation doing business in Iowa. See subrule 46.4(8) for the exemption from withholding for partnership distributions from certain publicly traded partnerships.

9. The Iowa gross income of a nonresident who is employed and receiving compensation for services shall include compensation for personal services which are rendered within this state. Compensation for personal services rendered by a nonresident wholly without the state is excluded from gross income of the nonresident even though the payment of such compensation may be made by a resident individual, partnership or corporation.

10. The gross income from commissions earned by a nonresident traveling salesperson, agent or other employee for services performed or sales made whose compensation depends directly on volume of business transacted by the nonresident, includes that proportion of the total compensation received which the volume of business or sales by the employee within this state bears to the total volume of business or sales within and without the state.

11. Payments made to landlords by agents, including elevator operators, for grain or other commodities which have been received by the landlord as rent constitute taxable income of the landlord when sold by the landlord. See subrule 46.4(6) for the exemption from withholding on incomes paid to nonresidents for the sale of agricultural commodities or products.

12. Wages paid to nonresidents of Iowa who earn the compensation from regularly assigned duties in Iowa and one or more other states for a railway company or for a motor carrier are not taxable to Iowa. Pursuant to the Amtrak Reauthorization and Improvement Act of 1990, the nonresidents in this situation are subject only to the income tax laws of their states of residence. Thus, when an Iowa resident performs regularly assigned duties in two or more states for a railroad or a motor carrier, the only state income tax that should be withheld from the wages paid for these duties is Iowa income tax.

13. Wages paid to nonresidents of Iowa who earn compensation from regularly assigned duties in Iowa and one or more states for an airline company. In accordance with Public Law 103-272 enacted by Congress, airline employees who are nonresidents of Iowa are subject only to the income tax laws of their states of residence or the state in which they perform 50 percent or more of their duties.

14. Wages paid to nonresidents of Iowa who earn compensation from regularly assigned duties in Iowa for a merchant marine company. In accordance with Public Law 106-489 enacted by Congress, interstate waterway workers who are nonresidents of Iowa are subject only to the income tax laws of their states of residence.

46.4(3) *Nonresident certificate of release.* Where a nonresident payee makes the option to pay estimated Iowa income tax, a certificate of release from withholding will be issued by the Iowa department of revenue to the designated payers. The certificate of release will be forwarded to the specified withholding agent(s) and payer(s), and will state the amount of income covered by the estimated tax payment. Any income paid in excess of the amount so stated will be subject to withholding tax at the current rate. See 701—Chapter 49 for information on making estimate payments.

46.4(4) *Recovering excess tax withheld.* A nonresident payee may recover any excess Iowa income tax withheld from income of the payee by filing an Iowa income tax return after the close of the tax year and reporting income from Iowa sources in accordance with the income tax return instructions.

46.4(5) *Exemption from withholding of nonresidents engaged in film production or television production in this state.* Nonresidents engaged in film production or television production in this state are not subject to state withholding on wages earned from this activity if the nonresidents' employer has applied to the department for exemption from withholding of state income tax and the employer's application includes the following information about the nonresident employees:

- a. The employees' names.
- b. The employees' permanent mailing addresses.
- c. The employees' social security numbers.
- d. The estimated amounts the employees are to be paid for services provided by the employees in this state.

The employer's application for exemption from withholding for the nonresident employees will not be approved by the department if the employer fails to provide all the required information.

Only those nonresident employees described in the application for exemption from withholding will be covered when the application is approved by the department. If additional nonresident employees are hired after the initial application for exemption is filed, those employees should be described in an amendment to the application for exemption which must be filed with the department of revenue.

Applications for exemption from withholding for nonresident employees engaged in film production or television production should be directed to the Iowa Department of Revenue, Compliance Division, Examination Section, Hoover State Office Building, P.O. Box 10456, Des Moines, Iowa 50306.

46.4(6) *Exemption from withholding for the sale of agricultural commodities or products.* Withholding agents are not required to withhold state income tax from income payments made to nonresidents or representatives of the nonresidents for the sales of agricultural commodities or products, if the withholding agents provide certain information to the department of revenue about the sales. The following paragraphs describe the agricultural commodities and products that are included in the exemption from withholding, specify the information needed on the sales and clarify other issues related to the exemption from withholding. 701—subrule 49.3(4) describes an election for withholding agents to make estimate payments on behalf of nonresident taxpayers for net incomes of the nonresidents from agricultural commodities or products.

a. Agricultural commodities or products included in the exemption from withholding. Withholding agents are not required to withhold state income tax from income payments they make to nonresidents or representatives of the nonresidents for the sale of commodity credit certificates, grain (corn, soybeans, wheat, oats, etc.), livestock (cattle, hogs, sheep, horses, etc.), domestic fowl (chickens, ducks, turkeys, geese, etc.), or any other agricultural commodities or products, if the withholding agents provide the department of revenue with the information specified in paragraph "b" of this subrule.

b. Information to be provided to the department by withholding agents claiming exemption from withholding on income payments made to nonresidents for the sales of agricultural items. The following information is to be provided on a listing to the department of revenue by withholding agents electing exemption from withholding of state income tax on income payments made in the calendar year to nonresidents or representatives of the nonresidents on the sales of agricultural commodities or products made in the year:

- (1) Name of the nonresident (last name, first name and middle initial).
- (2) Home address of the nonresident.
- (3) Social security number of the nonresident.
- (4) Aggregate payments made in the calendar year for the nonresident (includes payments made to a representative of the nonresident on behalf of the nonresident).
- (5) Two-digit Iowa county code number of the first one of the following that applies to the nonresident:
 1. County in which the nonresident owns real property or personal property.
 2. County in which the nonresident leases real property or personal property.
 3. County in which the nonresident has agricultural products stored or in which livestock is located.
 4. County where the nonresident has performed custom farming activities in the year.

5. County where the nonresident has other business activities in Iowa other than merely sales activities.

If a nonresident does not own or lease property in Iowa or have other connection with Iowa as described in subparagraph 46.4(6)“b”(5), items “3,” “4,” and “5,” the nonresident is not subject to Iowa income tax on the income payments for agricultural commodities or products and the nonresident’s income payments should not be included on the listing.

In a situation where a withholding agent is unable to get all the information that is to be provided to the department on income payments on sales of agricultural items, the agent is relieved of the requirement to withhold if the agent can provide written evidence showing an attempt was made to acquire all the information.

The listing of aggregate income payments to nonresidents with an Iowa connection for sales of agricultural commodities and products in the calendar year should be sent to the department by the withholding agent on or before April 1 of the year following the year in which the income payments were made. In lieu of the listing, the withholding agent may compile the information on aggregate income payments to nonresidents on a magnetic tape, diskette or other electronic reporting, provided the submission meets departmental guidelines described in 701—paragraph 8.3(1)“e.”

The listing, magnetic tape or other electronic submission should be sent to the following address: Iowa Department of Revenue, Compliance Division, Examination Section, Hoover State Office Building, P.O. Box 10456, Des Moines, Iowa 50306; idr@iowa.gov.

A withholding agent is not exempt from withholding of state income tax on income payments to nonresidents on sales of agricultural commodities or products if the withholding agent does not provide the department of revenue with information on income payments made during the year by April 1 of the subsequent year.

c. Rescinded IAB 3/2/05, effective 4/6/05.

46.4(7) *Exemption from withholding of payments made to nonresidents for deferred compensation, pensions, and annuities.* Iowa income tax withholding is not required from payments of deferred compensation, pensions, and annuities made to nonresidents which are attributable to personal services of the nonresidents in Iowa since these payments are not subject to Iowa income tax. See rule 701—40.45(422) for the exclusion from Iowa income tax for these payments received by nonresidents.

46.4(8) *Exemption from withholding of partnership distributions made to nonresidents of certain publicly traded partnerships.* For tax years beginning on or after January 1, 2008, a nonresident who is a partner in a publicly traded partnership as defined in Section 7704(b) of the Internal Revenue Code is not subject to state withholding tax on the partner’s pro rata share, provided that the publicly traded partnership submits the following information to the department for each partner whose Iowa income from the partnership exceeded \$500:

- a.* Partner’s name.
- b.* Partner’s address.
- c.* Partner’s taxpayer identification number.
- d.* Partner’s pro rata share of Iowa income from the partnership for the tax year.

A partnership is a publicly traded partnership if the interests in the partnership are traded on an established securities market or the interests in the partnership are readily traded on a secondary market or its substantial equivalent.

46.4(9) *Exemption from withholding of payments made to an out-of-state business or out-of-state employee due to state-declared disaster.* On or after January 1, 2016, see 701—Chapter 242 for withholding requirements of an out-of-state business or out-of-state employee who enters Iowa to perform disaster and emergency-related work during a disaster response period as those terms are defined in Iowa Code section 29C.24.

This rule is intended to implement Iowa Code section 422.15, Iowa Code section 422.16 as amended by 2007 Iowa Acts, House File 923, section 3, and Iowa Code sections 422.17 and 422.73.

[ARC 7761B, IAB 5/6/09, effective 6/10/09; ARC 3085C, IAB 5/24/17, effective 6/28/17]

701—46.5(422) Penalty and interest.

46.5(1) Penalty. See rule 701—10.6(421) for penalty for tax periods beginning on or after January 1, 1991. See rule 701—10.8(421) for statutory exemptions to penalty for tax periods beginning on or after January 1, 1991.

46.5(2) Computation of interest on unpaid tax. Interest shall accrue on tax due from the original due date of the return. Interest on refunds of any portion of the tax imposed by statute which has been erroneously refunded and which is recoverable by the department shall bear interest as provided by law from the date of payment of the refund, with each fraction of a month considered to be an entire month. See rule 701—10.2(421) for the statutory interest rate.

All payments shall be first applied to the penalty and then to the interest, and the balance, if any, to the amount of tax due.

46.5(3) Computation of interest on overpayments. If the amount of tax determined to be due by the department is less than the amount paid, the excess to be refunded will accrue interest from the first day of the second calendar month following the date of payment or the date the return was due to be filed or was filed, whichever is the later.

This rule is intended to implement Iowa Code sections 421.27, 422.16 and 422.25.

701—46.6(422) Withholding tax credit to workforce development fund. Upon payment in full of a certificate of participation or other obligation issued to fund a job training program under Iowa Code chapter 260E, the community college which provided the training is to notify the economic development authority of the amount paid by the employer or business to the community college during the previous 12 months. The economic development authority is to notify the department of revenue of this amount. The department is to credit 25 percent of this amount to the workforce development fund in each quarter for the next ten years from the withholding tax paid by the employer or business. If the withholding tax paid by the employer or business for a quarter is not sufficient to cover the sum to be credited to the workforce development fund, the sum to be credited is to be reduced accordingly. The aggregate amount from all employers to be transferred to the workforce development fund in a year is not to exceed \$4 million for fiscal years beginning on or after July 1, 2001, but before July 1, 2014. The aggregate amount is not to exceed \$5,750,000 for the fiscal year beginning July 1, 2014, and the aggregate amount is not to exceed \$6,000,000 for fiscal years beginning on or after July 1, 2015.

This rule is intended to implement Iowa Code section 422.16A as amended by 2014 Iowa Acts, House File 2460.

[ARC 1665C, IAB 10/15/14, effective 11/19/14]

701—46.7(422) ACE training program credits from withholding. The accelerated career education (ACE) program is a training program administered by the Iowa department of economic development to provide technical training in state community colleges for employees in highly skilled jobs in the state to the extent that the training is authorized in an agreement between an employer or group of employers and a community college for the training of certain employees of the employer or group of employers. If a community college and an employer or group of employers enter into a program agreement for ACE training, a copy of the agreement is to be sent to the department of revenue. No costs incurred prior to the date of the signing between a community college and an employer or group of employers may be reimbursed or are eligible for program job credits, including job credits from withholding unless the costs are incurred on or after July 1, 2000.

46.7(1) The costs of the ACE training program may be paid from the following sources:

- a. Program job credits which the employer receives on the basis of the number of program job positions agreed to by the employer for the training program;
- b. Cash or in-kind contributions by the employer toward the costs of the program which must be at least 20 percent of the total cost of the program;
- c. Tuition, student fees, or special charges fixed by the board of directors of the community college to defray costs of the program;
- d. Guarantee by the employer of payments to be received under paragraphs “a” and “b” of this subrule.

This rule pertains only to the program job credits from withholding described in paragraph “a.”

46.7(2) ACE training programs financed by job credits from withholding. In situations when an employer or group of employers and a community college have entered into an agreement for training under the ACE program and the agreement provides that the training will be financed by credits from withholding, the amount of funding will be determined by the program job credits identified in the agreement. Eligibility for the program job credits is based on certification of program job positions and program job wages by the employer at the time established in the agreement with the community college. An amount of up to 10 percent of the gross program job wage as certified by the employer in the agreement shall be credited from the total amount of Iowa income tax withheld by the employer. For example, if there were 20 employees designated to be trained in the agreement and their gross wages were \$600,000, the gross program job wage would be \$600,000. Therefore, 10 percent of the gross program job wage in this case would be \$60,000, and this amount would be credited against Iowa income tax which would ordinarily be withheld from the wages of all employees of the employer and remitted to the department of revenue on a quarterly basis. The amount credited against the withholding tax liability of the employer would be paid to the community college training the employer’s employees under the ACE program. The employer may take the credits against withholding tax on returns filed with the department of revenue until such time as the program costs of the ACE program are considered to be satisfied.

This rule is intended to implement Iowa Code sections 260G.4A and 422.16.

701—46.8(260E) New job tax credit from withholding. The Iowa industrial new jobs training program is a program administered by the economic development authority for projects established by a community college for the creation of jobs by providing education and training of workers for new jobs for new or expanding industries. For employers that have entered into an agreement with a community college under Iowa Code chapter 260E, a credit equal to 1.5 percent of the wages paid by the employer to each employee covered by the agreement can be taken on the Iowa withholding tax return. If the amount of withholding by the employer is less than 1.5 percent of the wages paid to the employees covered by the agreement, the employer can take the remaining credit against Iowa tax withheld for other employees. An employee does not include a resident of Illinois who earns wages in Iowa since these employees are not subject to Iowa withholding tax in accordance with the Iowa-Illinois reciprocal tax agreement discussed in 701—subrule 38.13(1). The administrative rules for the Iowa industrial new jobs training program administered by the economic development authority may be found in 261—Chapter 5.

This rule is intended to implement Iowa Code section 260E.2 as amended by 2012 Iowa Acts, Senate File 2212, and section 260E.5.

[ARC 0337C, IAB 9/19/12, effective 10/24/12]

701—46.9(15) Supplemental new jobs credit from withholding and alternative credit for housing assistance programs.

46.9(1) *Supplemental new jobs credit from withholding.* For eligible businesses approved by the economic development authority under Iowa Code section 15A.7, a credit equal to an additional 1.5 percent of the wages paid to employees in new jobs for these eligible businesses can be taken on the Iowa withholding tax return. This supplemental new jobs credit is in addition to the credit described in rule 701—46.8(260E). The administrative rules for the supplemental new jobs credit from withholding may be found in 261—paragraph 59.6(3)“a.”

46.9(2) *Alternative credit for housing assistance programs.* As an alternative to the credit described in subrule 46.9(1) for eligible businesses in an enterprise zone, a business may provide a housing assistance program in the form of down payment assistance or rental assistance for employees in new jobs. A credit equal to 1.5 percent of the wages paid to employees participating in a housing assistance program may be claimed on the Iowa withholding tax return for wages paid prior to July 1, 2009. Effective July 1, 2009, the alternative credit for housing assistance programs was repealed. The

administrative rules for the enterprise zone program administered by the Iowa department of economic development may be found in 261—Chapter 59.

This rule is intended to implement Iowa Code section 15A.7 and 2014 Iowa Code sections 15E.196 and 15E.197.

[ARC 8605B, IAB 3/10/10, effective 4/14/10; ARC 1744C, IAB 11/26/14, effective 12/31/14]

701—46.10(403) Targeted jobs withholding tax credit. For employers that enter into a withholding agreement with pilot project cities approved by the economic development authority and create or retain targeted jobs in a pilot project city, a credit equal to 3 percent of the gross wages paid to employees under the withholding agreement can be taken on the Iowa withholding tax return. The employer shall remit the amount of the credit to the pilot project city. The administrative rules for the targeted jobs withholding tax credit program administered by the economic development authority may be found in 261—Chapter 71.

If the amount of withholding by the employer is less than 3 percent of the wages paid to the employees covered under the withholding agreement, the employer can take the remaining credit against Iowa tax withheld for other employees or may carry the credit forward for up to ten years or until depleted, whichever is the earlier.

If an employer also has a new job credit from withholding provided in rule 701—46.8(260E) or the supplemental new jobs credit from withholding provided in subrule 46.9(1), these credits shall be collected and disbursed prior to the collection and disbursement of the targeted jobs withholding tax credit.

The following nonexclusive examples illustrate how this rule applies:

EXAMPLE 1: Company A does not have a withholding credit under Iowa Code chapter 260E or a supplemental new jobs credit under Iowa Code chapter 15E. Company A enters into a withholding agreement, and the withholding rate for employees covered under the agreement is 4 percent of the wages paid. Company A will be allowed a credit on the Iowa withholding return equal to 3 percent of the wages paid to each employee covered under the withholding agreement, since the targeted jobs withholding tax credit cannot exceed 3 percent.

EXAMPLE 2: Company B does not have a withholding credit under Iowa Code chapter 260E or a supplemental new jobs credit under Iowa Code chapter 15E. Company B enters into a withholding agreement, and the withholding rate for employees covered under the agreement is 2.5 percent of the wages paid. Company B will be allowed a credit on the Iowa withholding return equal to 3 percent of the wages paid to each employee covered under the withholding agreement. The extra withholding credit equal to 0.5 percent may be used to offset withholding tax for Company B's employees not covered under the withholding agreement.

EXAMPLE 3: Company C has a withholding credit under Iowa Code chapter 260E of 1.5 percent of the wages paid to new employees and a supplemental new jobs credit under Iowa Code chapter 15E of 1.5 percent of the wages paid to new employees. Company C also enters into a withholding agreement for the same employees covered under the 260E agreement and supplemental new jobs credit agreement, and the withholding rate for employees covered under these agreements is 5 percent of the wages paid. Company C will be allowed a credit on the Iowa withholding return equal to 5 percent of the wages paid to each employee covered under these agreements. Since the community college receives disbursement of the credit before the pilot project city, the community college will receive 3 percent of the wages paid to each employee covered under the agreements, and the pilot project city will receive the remaining 2 percent of the wages paid to each employee covered under the agreements.

EXAMPLE 4: Company D has a withholding credit under Iowa Code chapter 260E of 1.5 percent of the wages paid to new employees and a supplemental new jobs credit under Iowa Code chapter 15E of 1.5 percent of the wages paid to new employees. Company D also enters into a withholding agreement for the same employees covered under the 260E agreement and supplemental new jobs credit agreement, and the withholding rate for employees covered under the agreement is 2.5 percent of the wages paid. Company D will be allowed a credit on the Iowa withholding tax return equal to 6 percent of the wages

paid to each employee covered under these agreements. The extra withholding credit equal to 3.5 percent may be used to offset withholding tax for Company D's employees not covered under these agreements.

46.10(1) Notification by the employer. Once a withholding agreement is entered into with a pilot project city, the employer shall notify the department of revenue that an agreement has been executed. With this notification, the employer must also provide its address, tax identification number and the number of new jobs created under the agreement. In addition, for each year that the withholding agreement is in place, the employer must notify the department of revenue by January 31 of the number of new jobs created as of December 31 of the preceding year.

46.10(2) Notification by the pilot project city. The pilot project city must notify the department of revenue on a quarterly basis of the amount of the targeted jobs withholding credit that each employer covered by a withholding agreement remitted to the city. This notification must occur within 45 days after the end of each calendar quarter. In addition, the pilot project city must notify the department of revenue immediately when a withholding agreement with an employer is terminated.

This rule is intended to implement Iowa Code section 403.19A as amended by 2013 Iowa Acts, Senate File 433.

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TRANSPORTATION DEPARTMENT[761]

Rules transferred from agency number [820] to [761] to conform with the reorganization numbering scheme in general IAC Supp. 6/3/87.

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CHAPTER 118
LOGO SIGNING

761—118.1(306C) Introduction. Logo signing consists of individual business signs attached to specific service signs erected by the department within the right-of-way of interstate and freeway-primary highways. The purpose of logo signing is to provide specific motorist service information of interest to the traveling public. Logo signing shall comply with this chapter and the “Manual on Uniform Traffic Control Devices,” as adopted in rule 761—130.1(321). The department shall perform all required installation, maintenance, removal and replacement of specific service signs and business signs within the right-of-way. The business signs are provided by the applicants.

[ARC 2645C, IAB 8/3/16, effective 9/7/16]

761—118.2(306C) Definitions.

“*Business sign*” means a separate sign attached to a specific service sign; the business sign shows the name, symbol or trademark of a business that provides the type of motorist service identified on the specific service sign.

“*General service sign*” means an official guide sign that identifies general road user services such as gas, food, lodging and camping. This sign does not provide for the placement of business signs.

“*Mainline*” means the main-traveled way of an interstate or a freeway-primary highway.

“*Motorist service*” means one of the following five types of services: gas, food, lodging, camping or attraction.

“*Qualified business*” means a business that meets all requirements to participate in the logo signing program and meets all qualifications pertaining to a particular type of motorist service without the granting of an exception.

“*Ramp*” means the exit lane which carries decelerating traffic away from the mainline of an interstate or a freeway-primary highway.

“*Specific service sign*” means an official guide sign that identifies one or more types of motorist services, provides directional information, and has spaces for the attachment of business signs to identify businesses providing those services.

“*Trailblazing sign*” means a specific service sign erected on the road network accessed from an interchange that has logo signing; the sign directs motorists to a particular business signed on the mainline and has spaces for the attachment of business signs.

[ARC 2645C, IAB 8/3/16, effective 9/7/16; ARC 5491C, IAB 3/10/21, effective 4/14/21]

761—118.3(306C) Erection and location of specific service signs and placement of business signs.

118.3(1) General.

a. The department shall erect specific service signs at rural interchanges if the requirements of this chapter are met and sufficient space is available. The department may also erect specific service signs at urban, or nonrural interchanges if the requirements of this chapter are met and sufficient space is available. If sufficient space is not available for more than one specific service sign, the department may install a general service sign in lieu of a specific service sign.

b. Specific service signs shall be erected at an interchange only when the motorist can conveniently reenter the interstate or freeway-primary highway and continue in the same direction of travel.

118.3(2) Mainline specific service signs and placement of business signs. Following are the requirements for mainline specific service signs erected in advance of an interchange, in a single direction of travel, and limitations regarding the number and types of business signs attached to these service signs.

a. As spacing permits, a maximum of four mainline specific service signs may be erected in advance of an interchange from which motorist services are available.

b. The minimum spacing required between mainline specific service signs and between mainline specific service signs and other official guide or destination signs on the mainline is 800 feet.

c. If spacing limitations and the four-sign limit prohibit the erection of mainline specific service signs for the types of motorist services available, preference shall be given to available gas, food, lodging, camping or attraction services, in that order.

d. If services are displayed, the order of display of services in the direction of travel on successive mainline specific service signs is as follows: attraction, camping, lodging, food, and gas.

e. Each mainline specific service sign is limited to six business signs. This restriction applies regardless of whether the specific service sign displays a single type of motorist service or a combination of service types.

f. In general, only one type of motorist service should be displayed on each mainline specific service sign. However, the department may combine service types on one sign for a reason such as, but not limited to, the following:

- (1) There is limited space available on the mainline for specific service signs.
- (2) There is limited interest from qualified businesses or limited availability of motorist services at the interchange.
- (3) There is an imbalance of qualified businesses between service types.

g. The requirements for mainline specific service signs that display a combination of motorist services are as follows:

- (1) Each combination sign is limited to six business signs.
- (2) No more than three types of motorist services shall be represented on any combination sign.
- (3) For a combination sign displaying three types of motorist services, the number of business signs for each service type is limited to two.
- (4) For a combination sign that will accommodate at least four business signs, each type of motorist service displayed on the sign must have at least two positions designated for that service type.

h. Either preference or equal representation shall be given for higher priority service types, as set out in paragraph "c" of this subrule, depending upon the motorist services available at the interchange, the interest expressed by qualified businesses in the logo signing program, and the anticipated future development of the area near the interchange.

i. In a single direction of travel, the total number of business signs displayed for a single type of motorist service is limited to 12, and no more than two mainline specific service signs shall display business signs for a single service type.

j. The department shall designate each mainline specific service sign for a particular type of motorist service, although the service sign may, in use, be displaying more than one service type, subject to paragraph "h" of this subrule. When a specific service sign designated for a particular service type exists and that sign is full, the department may grant an exception, in accordance with subrule 118.4(11), to allow the placement of a business sign for that service type on a specific service sign designated for another service type, provided that the department has displayed the legend for that service type on the service sign.

118.3(3) Ramp specific service signs and placement of business signs.

a. On a single-exit interchange, the department shall erect a ramp specific service sign if businesses for that type of motorist service are signed on the corresponding mainline specific service sign and one or more of these businesses or their on-premises signing is either not visible from the mainline or is not visible from the ramp at or before the point where a motorist needs to make a lane decision or turning decision. However:

- (1) The department shall not erect ramp specific service signs if ramp design or spacing limitations prohibit the erection of these signs.
- (2) The department may erect a general service sign on the ramp for the appropriate service type in lieu of a ramp specific service sign.
- (3) If all services represented by business signs on the mainline specific service signs are located the same direction from the interchange, the department may erect a general service sign on the ramp in lieu of ramp specific service signs.

b. The number of ramp specific service signs that may be erected, the order of preference when space for ramp signs is limited, and the order in which motorist services are displayed on successive

ramp signs are the same as the requirements for mainline specific service signs. Also, each ramp specific service sign is limited to six business signs.

c. Ramp specific service signs shall not be erected on double-exit interchanges.

d. If a business sign for a motorist service is displayed on a mainline specific service sign, the department has erected a ramp specific service sign for that service type, and the department has determined that the business or its on-premises signing is either not visible from the mainline or is not visible from the ramp at or before the point where a motorist needs to make a lane decision or turning decision, then a ramp business sign corresponding to the mainline business sign is required.

e. A ramp business sign is allowed only if it has a corresponding business sign displayed on a mainline specific service sign.

118.3(4) Trailblazing signs and placement of business signs.

a. Trailblazing signs are required for a business that has a business sign displayed on a mainline specific service sign when the business is neither located on nor is visible from the road that intersects the mainline at the logo-signed interchange.

b. Trailblazing signs are used only on non-fully controlled access highways and are installed only for businesses that have business signs displayed on mainline specific service signs.

c. The department shall install trailblazing signs on routes under its jurisdiction and shall make signs available for local jurisdictions to place on routes within their jurisdictions.

d. Trailblazing signs shall not display more than four business signs.

e. The department may approve the use of an official traffic control device that is placed by the department or a local jurisdiction on the public right-of-way in compliance with the “Manual on Uniform Traffic Control Devices” as a substitute for a trailblazing sign.

f. If site or other conditions do not permit the erection of a trailblazing sign, the department may approve the use of an off-premises advertising device as a substitute for a trailblazing sign if the advertising device complies, as applicable, with 761—Chapter 117 (including permit requirements) and any local regulations; the device is legible and understandable; and the device is placed along the route in advance of the intersection where the trailblazing sign would have been placed.

g. No more than two trailblazing signs, including approved substitutes, are allowed for a business. If the department determines that more than two trailblazing signs, including approved substitutes, would be needed to guide motorists to the business, the business does not qualify for logo signing at the interchange. Also, if the department determines that one or two trailblazing signs or approved substitutes are required and conditions do not permit the erection of the required trailblazing signs or approved substitutes, the business does not qualify for logo signing at the interchange.

[ARC 2645C, IAB 8/3/16, effective 9/7/16]

761—118.4(306C) Eligibility for placement of business signs on mainline specific service signs. To qualify for placement of a business sign on a mainline specific service sign, the business shall be open to the general public, shall not restrict entrance based on age, and shall meet the following requirements:

118.4(1) Discrimination prohibited. As a condition of approval as a participant in the logo signing program, the applicant shall give the department written assurance of the business’s conformity with all applicable laws prohibiting discrimination based on age, race, creed, color, sex, sexual orientation, gender identity, national origin, religion or disability, and a participant shall not be in breach of that assurance.

118.4(2) Maximum distance from exit.

a. Three-mile limit of eligibility. The maximum distance that a business may be located from the exit to qualify for a business sign shall not exceed three miles in either direction. The distance shall be measured from the beginning of the widening for the deceleration ramp at the exit to the entrance of the business.

b. Limit of eligibility reduced to one mile. In urban areas where the number of qualified businesses for a particular type of motorist service exceeds six within the three-mile limit, the department may reduce the maximum distance to one mile for that service type.

c. Exceptions. If there is space for additional business signs on a mainline specific service sign for a particular type of motorist service and no businesses which provide that motorist service within the limit of eligibility have expressed an interest to the department in the space, the department may grant a distance exception, in accordance with subrule 118.4(11), to a business which provides that motorist service and is located within 15 miles of the exit.

118.4(3) Gas.

a. Qualifications. To qualify for placement of a business sign on a gas specific service sign, the business must:

- (1) Be appropriately licensed as required by law.
- (2) Provide vehicle services including gasoline, oil, and water.
- (3) Provide free air for tire inflation.
- (4) Provide restroom facilities and drinking water.
- (5) Operate year-round at least 12 continuous hours per day, 7 days per week.
- (6) Provide a public telephone.

b. Exceptions. Card-operated fueling stations may be granted an exception, in accordance with subrule 118.4(11), from the requirements to provide oil and water, restroom facilities, drinking water, and a public telephone. These fueling stations must operate 24 hours per day, 7 days per week, and must be operable by motorists without membership.

118.4(4) Food.

a. Qualifications. To qualify for placement of a business sign on a food specific service sign, the business must:

(1) Be appropriately licensed as required by law, including a state food service establishment license, except for a food service operated on Indian lands.

(2) Operate a minimum of 40 hours per week, six days per week, and serve at least two of the following meals per day: breakfast, lunch, or dinner.

1. At a minimum, breakfast shall be served from 10 a.m. to 11 a.m. and shall consist of at least two of the following items: eggs, bacon, ham, sausage, pancakes, waffles, oatmeal, cereal, fruit, muffins, toast, croissants, doughnuts or rolls and at least two of the following drinks: coffee, juice, tea or milk.

2. At a minimum, lunch shall be served from 11 a.m. to 1 p.m.

3. At a minimum, dinner shall be served from 5 p.m. to 7 p.m.

(3) Provide a public telephone.

(4) Have its own employees, seating, menu and cash register for the food service. The business sign must identify the entity providing the food service.

(5) Have seating available for a minimum of ten customers.

b. Seasonal operations. Food service may be operated seasonally. See subrule 118.5(7) for the fee options for seasonal operations.

118.4(5) Lodging.

a. Qualifications. To qualify for placement of a business sign on a lodging specific service sign, the business must:

(1) Be appropriately licensed as required by law.

(2) Provide adequate sleeping accommodations consisting of a minimum of ten units each. Each unit must have a bathroom and a sleeping room. However, a bed and breakfast establishment is not required to have more than two guest rooms or provide separate bathroom facilities for each room.

(3) Provide a public telephone.

b. Seasonal operations. Lodging service may be operated seasonally. See subrule 118.5(7) for the fee options for seasonal operations.

118.4(6) Camping.

a. Qualifications. To qualify for placement of a business sign on a camping specific service sign, the business must:

(1) Meet applicable state and local standards for health and sanitation.

(2) Have a minimum of 20 spaces for camping or parking of camping vehicles.

(3) When in operation, be available to the public 24 hours per day.

(4) Provide a public telephone.

b. Seasonal operations. Camping service may be operated seasonally. See subrule 118.5(7) for the fee options for seasonal operations.

118.4(7) Attraction.

a. Qualifications. To qualify for placement of a business sign on an attraction specific service sign, the site or attraction must:

- (1) Be appropriately licensed as required by law.
- (2) Be a site or attraction listed in paragraph “c” of this subrule.
- (3) Be of significant interest to the traveling public.
- (4) Be nationally or regionally known through a marketing or advertising plan or media articles and exposure.

(5) Maintain normal business hours at least five days per week, totaling at least 40 hours per week. Facilities listed in subparagraph 118.4(7) “c”(12) are exempted from this requirement.

(6) Have adequate parking accommodations, with a minimum of 30 parking spaces.

(7) Have restroom facilities available for use by the traveling public.

(8) Be approved by the tourist signing committee; see subrule 118.5(3).

b. Seasonal operations. The site or attraction may be operated seasonally. See subrule 118.5(7) for the fee options for seasonal operations.

c. Types of qualifying sites or attractions. The site or attraction must be one of the following:

- (1) Area of natural beauty or phenomena.
- (2) Historic site.
- (3) Cultural site or museum.
- (4) Scientific site.
- (5) Four-year accredited college or university.
- (6) Religious site.
- (7) Area of outdoor recreation.
- (8) Winery, brewery or distillery with on-site production, tours, gift shop, and tasting room.
- (9) Amusement park.
- (10) Botanical park or zoological facility.
- (11) Casino.
- (12) Stadium, coliseum, arena or racetrack with a seating capacity of at least 5,000.
- (13) Antique mall with at least 20,000 square feet devoted to retail sales.
- (14) Area containing eight or more antique shops within a three-block radius.
- (15) Shopping mall or retail outlet with a minimum, active store count of 50, excluding kiosks and temporary booths within the common areas, and including only those stores that occupy owned or leased areas whose boundaries are defined by permanent walls with doors or gates.

(16) Sporting goods store or recreational retail outlet with at least 100,000 square feet devoted to retail sales.

(17) Cultural and entertainment district as officially designated by the department of cultural affairs, provided that the local jurisdiction implements a signing plan to direct motorists to the various cultural and entertainment sites within the district.

118.4(8) Compliance with Iowa Code sections 306C.11 and 306C.13. The business must be in compliance with Iowa Code sections 306C.11 and 306C.13. If an advertising device which serves the business is erected or maintained in violation of either of these sections, that business shall be disqualified from obtaining or maintaining a business sign upon any specific service sign.

118.4(9) On-premises sign required. The business must erect and maintain a legal on-premises sign at the site where the service is provided. The sign must be visible to motorists at the entrance to the business premises.

118.4(10) Noncompliance. The department shall remove and dispose of a mainline business sign and the corresponding ramp and trailblazing business signs of a business that does not meet or no longer meets the requirements of this chapter. In order to have its business signs reinstalled, the business must

submit a new application to the department. The new application is subject to all the requirements of this chapter, including payment of the application fee and a drawing, if needed, to select applicants.

118.4(11) *Granting of exceptions.*

a. The department may grant an exception and approve the placement of a business sign on a mainline specific service sign for the following:

(1) When a specific service sign designated for a particular type of motorist service exists and that sign is full, placement of a business sign for that service type on a specific service sign designated for another service type. See paragraph 118.3(2)“*j.*”

(2) Maximum distance from the exit. See paragraph 118.4(2)“*c.*”

(3) Card-operated fueling stations. See paragraph 118.4(3)“*b.*”

b. If there is available space on a specific service sign and no application has been received by the department from a qualified business for that space, the department may allow an applicant to submit to the department for review a signed Exception Acknowledgement form along with a logo signing application.

c. The acknowledgement form states that if the department grants the exception and approves the application, the business is guaranteed a space on the specific service sign for at least five years if:

(1) The business pays the required fees in a timely manner;

(2) The business complies with all program requirements unrelated to the exception granted; and

(3) The department continues to maintain the specific service sign to which the business sign is attached.

d. After the five-year period has expired and at the end of the fiscal year, the department may remove the business sign from the specific service sign if:

(1) An exception was granted for maximum distance from the exit or a card-operated fueling station, an application has been received from a qualified business providing the same type of motorist service as the business granted the exception, and space is not available on that specific service sign.

(2) An exception was granted for the situation described in subparagraph 118.4(11)“*a*”(1); an application has been received from a qualified business for the service type designated for the specific service sign; and space is not available on that service sign.

[ARC 2645C, IAB 8/3/16, effective 9/7/16; ARC 5491C, IAB 3/10/21, effective 4/14/21]

761—118.5(306C) Application, drawing, and fees.

118.5(1) *Application.*

a. A business requesting placement of a business sign upon a mainline specific service sign shall submit a completed application form, provided by the department, along with the application fee, to the Advertising Management Section, Traffic and Safety Bureau, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

b. A separate application is not needed for the corresponding ramp business sign or trailblazing business signs. The department will advise the applicant what signs are required once the department approves the application.

c. Once the application is approved and the department has determined what business signs are required, the applicant shall furnish the department with business signs meeting department specifications.

d. Approved applications are valid for the fiscal year (July 1 to June 30) or portion thereof and expire on June 30. If the fees, as billed by the department, are paid by the business in accordance with subrule 118.5(5), the application is renewed on July 1.

118.5(2) *Drawing to select applicants.* If the number of applicants that are qualified businesses is greater than the number of vacant spaces on a mainline specific service sign, the department shall hold a drawing among these applicants to select the applicants to fill the vacant spaces. If no qualified businesses have applied for the vacant spaces, the department shall consider applicants that would qualify if exceptions were granted. If the number of these applicants is greater than the number of vacant spaces, the department shall hold a drawing among these applicants to select the applicants to fill the vacant spaces.

118.5(3) *Applications for attraction signing.* The department shall perform an initial review of all applications for attraction signing to determine if the attraction signing meets the technical requirements, such as the maximum distance the site or attraction is allowed to be from the interchange. If the site or attraction meets the technical requirements, the department shall submit the applications to the tourist signing committee. The tourist signing committee will determine whether the applications meet the qualifications set forth in subrule 118.4(7) for an attraction under the logo signing program. The composition of the committee is set out in 761—subrule 119.5(3).

118.5(4) *New application required for business name change.* If a business participating in the logo signing program changes its name or franchise affiliation from that which appears on its business sign, a new application is required. If the new application is received by the department prior to the change on the business premises, the business will retain its position on the specific service sign, the department will approve the application, and no application fee is due.

118.5(5) *Fees.* A business is required to pay the following fees to the department for participation in the logo signing program.

a. Application fee. For a new application, the application fee is \$100, except that no application fee is required for an application submitted in accordance with subrule 118.5(4) (business name change). The application fee is a one-time fee and is nonrefundable once the department has performed an on-site review to verify compliance with the requirements of this chapter. The application fee shall be submitted with the application.

b. Annual fee. The annual fee is \$230 for each business sign posted on a mainline specific service sign and \$230 for each business sign posted on a ramp specific service sign and is due on or before July 1 of each fiscal year (July 1 to June 30). However, for a new application, the department shall prorate the annual fee for the portion of the fiscal year that the business signs are installed and, following installation of the signs, shall invoice the business for the prorated annual fee; the fee is due within 30 days.

c. Service fee. The department may install replacement business signs at the request of the business and shall assess a \$50 service fee per business sign installed. The department shall also assess a \$50 service fee to install a renovated or new business sign that replaces a misleading, unsightly, badly faded or dilapidated sign, as specified in subrule 118.7(5). If removal of an existing business sign for the purpose of refurbishing is requested by the business, thereby requiring two service trips by the department, the service fee shall be applied per trip. The department shall invoice the business once installation is complete; the service fee is due within 30 days.

118.5(6) *Failure to pay annual fee or service fee.* Failure to pay the annual fee or service fee when due shall terminate the business's existing application on file with the department and shall be cause for removal and disposition of the affected business signs by the department. Termination of the application shall occur on the day of delinquency without respect to the date the department removes the business signs. In order to have its business signs reinstalled, the business must submit a new application to the department. The new application is subject to all of the requirements of this chapter, including payment of the application fee and a drawing, if needed, to select applicants.

118.5(7) *Fee options for seasonal operations.* Subject to subrule 118.5(5), a business that operates on a seasonal basis and is permitted to do so by this chapter has the following payment options:

a. Pay the annual fee for a full year. The department shall remove and reinstall each business sign once each year, free of additional charge, coinciding with the dates of operation, if possible.

b. Pay the annual fee for a prorated year, based on the calendar months in which the business is in operation, plus a \$50 annual service fee per business sign for removal and reinstallation services performed. The department shall remove and reinstall each business sign once each year, coinciding with the dates of operation, if possible.

c. Pay the annual fee for a prorated year, based on the calendar months in which the business is in operation, and provide mainline business signs that contain a supplemental message indicating the dates of operation. Ramp business signs, if required, may contain a supplemental message indicating the dates of operation. The supplemental message must comply with subrule 118.7(4).

118.5(8) *Fees for temporary specific service signs.* In cases where the attachment of a business sign will require the installation of a new or larger specific service sign, an applicant that wishes to have its

business sign installed sooner than the estimated date of installation as performed by the department's contractor may request the department to erect a temporary specific service sign. The time frame for erection of a temporary specific service sign will depend on the availability of department resources, but is typically one to three months. The applicant shall be charged a fee of \$700 per mainline specific service sign if none exists for that service type, \$400 per mainline specific service sign if the existing specific service sign is full, and \$300 per ramp specific service sign if a ramp business sign is required but cannot be accommodated on the existing ramp specific service sign. This is in addition to the fees specified in subrule 118.5(5). The applicant shall furnish the business sign to be attached to the temporary specific service sign. When the permanent specific service sign is erected, the department shall remove the business sign from the temporary specific service sign and reinstall it on the permanent specific service sign at no additional charge.

[ARC 2645C, IAB 8/3/16, effective 9/7/16; ARC 5491C, IAB 3/10/21, effective 4/14/21]

761—118.6(306C) Business sign blank specifications. Business signs shall meet the following specifications for the sign blank and shall not be installed until they are inspected and approved by the department.

118.6(1) Mainline business sign blank. Mainline business signs shall be fabricated from a rectangular sheet of aluminum, between 0.074 inches and 0.125 inches thick, with 3-inch radius corners. Gas business signs shall be 48 inches wide and 36 inches high. Food, lodging, camping and attraction business signs shall be 60 inches wide and 36 inches high.

118.6(2) Ramp business sign blank. Ramp business signs shall be fabricated from a rectangular sheet of aluminum, between 0.074 inches and 0.125 inches thick, with 2-inch radius corners. Gas business signs shall be 24 inches wide and 16 inches high. Food, lodging, camping and attraction business signs shall be 36 inches wide and 16 inches high.

118.6(3) Trailblazing business sign blank. Trailblazing business signs shall be fabricated from a rectangular sheet of aluminum, between 0.074 inches and 0.125 inches thick, with 2-inch radius corners. All trailblazing signs shall be 20 inches wide and 12 inches high.

761—118.7(306C) Business sign face specifications. Business signs shall meet the following specifications for the sign face and shall not be installed until they are inspected and approved by the department. Businesses shall submit a proposed sign design to the department for approval before proceeding with fabrication.

118.7(1) Design layout. A legend layout or a logo layout, but not both, shall be used for the design of the sign's message.

a. Legend layout. A legend layout shall reflect the name of the business in white letters on a blue background. Recommended letter height is 10 inches on a mainline business sign, 4 inches on a ramp business sign, and 3 inches on a trailblazing business sign. The recommended number of text lines is one or two. Reducing the letter height or adding a third text line will reduce the legibility of the message.

b. Logo layout. A logo layout shall reflect the nationally, regionally, or locally known symbol or trademark of the business, using colors consistent with customary use of the symbol or trademark and resembling the business's on-premises sign. The symbol or trademark may be modified to improve legibility.

118.7(2) Borders. Mainline business signs shall have a white $\frac{3}{4}$ -inch border on the outside edge of the sign. Ramp business signs shall have a white $\frac{1}{2}$ -inch border on the outside edge of the sign. Trailblazing business signs shall have a white $\frac{1}{2}$ -inch border on the outside edge of the sign. If a logo layout has a white background, no border is required. No inset border is allowed on legend layouts, and no inset border is allowed on logo layouts unless it is customary usage for the symbol or trademark.

118.7(3) Reflectorization. All business signs must be retroreflective.

118.7(4) Supplemental messages.

a. With department approval, a supplemental message such as "OPEN 24 HRS," "DIESEL," "E-85," "MECHANIC ON DUTY," "24 HR TOWING," "RV ACCESS," or the dates of operation for seasonal operations may be displayed on a mainline business sign provided the letter height is at least

5 inches. Approval shall be limited to essential motorist information and does not extend to messages such as, but not limited to, “INDOOR POOL,” “CAR WASH” or “PLAY AREA.”

b. With departmental approval, a scaled-down version of the supplemental message used on the mainline business sign may be displayed on ramp business signs provided the letter height is at least 2 inches.

c. Business signs are limited to one supplemental message per business sign.

118.7(5) *Misleading or dilapidated signs.* No business sign shall be displayed if it would mislead or misinform the traveling public, or if it is unsightly, badly faded, or dilapidated. The department may remove or mask business signs that violate these provisions. The department shall require a business to provide a renovated or new business sign to replace a misleading, unsightly, badly faded or dilapidated sign and shall assess a \$50 service fee to install the renovated or new sign.

118.7(6) *Signs that interfere with or imitate official signs.* Messages, trademarks, or brand symbols that interfere with, imitate, or resemble any official warning or regulatory traffic sign, signal or device are prohibited.

118.7(7) *Damaged signs.* The department is not responsible for damages to business signs caused by vandalism, vehicle accidents or acts of God. If a business sign is so damaged and it requires repair or replacement, the business shall provide a renovated or new business sign to the department for replacement of the damaged business sign. If a specific service sign is damaged beyond repair, the department shall erect a temporary specific service sign to accommodate the reattachment of the affected business signs.

[ARC 2645C, IAB 8/3/16, effective 9/7/16]

761—118.8(306C) RV symbol. Rescinded ARC 2645C, IAB 8/3/16, effective 9/7/16.

These rules are intended to implement Iowa Code section 306C.11.

[Filed 5/11/87, Notice 3/11/87—published 6/3/87, effective 7/8/87]

[Filed 8/7/96, Notice 7/3/96—published 8/28/96, effective 10/2/96]

[Filed 5/12/99, Notice 3/24/99—published 6/2/99, effective 7/7/99]

[Filed 11/7/02, Notice 9/4/02—published 11/27/02, effective 1/1/03]

[Filed 10/11/07, Notice 8/15/07—published 11/7/07, effective 12/12/07]

[Filed ARC 2645C (Notice ARC 2543C, IAB 5/25/16), IAB 8/3/16, effective 9/7/16]

[Filed ARC 5491C (Notice ARC 5314C, IAB 12/16/20), IAB 3/10/21, effective 4/14/21]

CHAPTER 136
LIGHTING

[Prior to 6/3/87, Transportation Department[820]—(06,K) Ch 4]

761—136.1(306,318) Lighting of primary-secondary intersections. The purpose of this rule is to establish the qualification criteria for, the procedures to request, and the financial responsibilities for the placement of roadway luminaires within the limits of the primary road right-of-way at a rural intersection of a primary road and a paved secondary road.

136.1(1) Lighting criteria. A primary-secondary intersection is a candidate for lighting if one of the following is met:

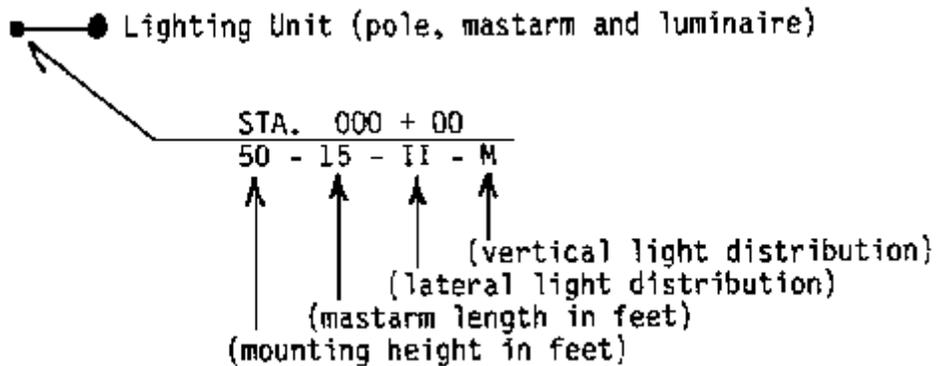
- a. The night-to-day accident rate ratio is 2.0 or greater with a minimum of three reportable nighttime accidents in a 12-month period.
- b. Substantial lighted commercial or business development that is affecting operations exists adjacent to the intersection.
- c. Motorists are experiencing operational problems which might be expected to be reduced by lighting.
- d. The current average daily traffic (ADT) is 3500 entering vehicles for the intersection and:
 - (1) The intersection is channelized or “T,” or
 - (2) A change in the direction of the major route occurs.

136.1(2) Reserved.

136.1(3) Procedures.

a. A request for lighting shall be made by the county to the appropriate district engineer. The request shall indicate the type and size of luminaires proposed, sight distance measurements and posted speed. If the county is requesting that the department participate in the installation costs as a C-STEP (County-State Traffic Engineering Program) project, this should be indicated in the request. A lighting plan shall accompany the request showing:

- (1) The complete dimensions of the intersection including pavement and shoulders.
- (2) The locations of proposed luminaires and poles.
- (3) The mounting heights, mast arm lengths, lateral and vertical light distributions of proposed luminaires and the approximate location for electrical service.



- b. The district engineer shall forward the request to the department’s traffic and safety bureau for review.
- c. If design requirements are satisfied, the department shall approve the lighting installation.
 - (1) The county shall be responsible for designing and installing the lighting and for all future energy and maintenance costs.
 - (2) If the location qualifies for lighting installation and if funds are available, the department shall share the installation costs on the basis of the current C-STEP participation ratio.
 - (3) If the department does not share the installation costs but the county wishes to install the lighting, the county shall be responsible for the installation costs.

d. If the department will share the installation costs, the department shall prepare an agreement for departmental and county approval.

This rule is intended to implement Iowa Code sections 306.4(1), 318.1, 318.2, 318.4, 318.5, 318.8, 318.9 and 318.12.

[ARC 5492C, IAB 3/10/21, effective 4/14/21]

761—136.2(306,318) Destination lighting. The purpose of this rule is to establish the application procedure and financial responsibilities for the placement of a roadway luminaire within the limits of primary road right-of-way at a rural intersection of a primary road and a minor road.

136.2(1) Definition.

“*Minor road,*” for the purposes of this rule, is an entrance to a primary road from a frontage road, a rural commercial establishment, a governmental agency facility, a generator of a substantial traffic volume, or a secondary road.

136.2(2) Reserved.

136.2(3) Procedures.

a. Application shall be made to the appropriate district engineer on Form 810025, “Application and Agreement for Use of Highway Right-of-Way for Utilities Accommodation.” Form 810025 is available on the department’s website at www.iowadot.gov. The application shall indicate the type of luminaire and intensity of illumination proposed. A sketch shall accompany the application showing the location of the proposed luminaire and pole and the mounting height of the luminaire.

b. The district engineer shall be responsible for departmental approval of the application. A copy of the application indicating the district engineer’s determination shall be returned to the applicant. Approved applications are termed “permits.”

c. The applicant shall be responsible for installing the lighting and for all installation, energy and maintenance costs.

This rule is intended to implement Iowa Code sections 306.4(1), 318.1, 318.2, 318.4, 318.5, 318.8, 318.9 and 318.12.

[ARC 5492C, IAB 3/10/21, effective 4/14/21]

761—136.3 to 136.5 Reserved.

761—136.6(306,318) Warrants and design requirements for lighting.

136.6(1) Warrants. Meeting departmental warrants or criteria for lighting simply establishes the location as a candidate for lighting. It does not obligate the department to provide lighting or to participate in lighting costs.

136.6(2) Design requirements. The design of lighting installations shall comply with departmental specifications and standard road plans for highway lighting as they exist at the time of installation of the lighting. The departmental specifications and standard road plans can be found through the department’s electronic reference library on the department’s website.

This rule is intended to implement Iowa Code sections 306.4(1), 318.1, 318.2, 318.4, 318.8 and 318.9.

[ARC 5492C, IAB 3/10/21, effective 4/14/21]

[Filed 7/1/75]

[Filed 3/12/79, Notice 1/24/79—published 4/4/79, effective 5/9/79]

[Filed 12/10/86, Notice 10/8/86—published 12/31/86, effective 2/4/87]

[Filed 5/11/87, Notice 3/11/87—published 6/3/87, effective 7/8/87]

[Filed 8/26/88, Notice 7/13/88—published 9/21/88, effective 10/26/88]

[Filed 8/7/02, Notice 6/26/02—published 9/4/02, effective 10/9/02]

[Filed ARC 5492C (Notice ARC 5341C, IAB 12/30/20), IAB 3/10/21, effective 4/14/21]

CHAPTER 180
PUBLIC IMPROVEMENT QUOTATION PROCESS FOR GOVERNMENTAL ENTITIES FOR
VERTICAL INFRASTRUCTURE

761—180.1(314) Purpose. The purpose of these rules is to prescribe the manner by which governmental entities shall administer competitive quotations for public improvement contracts for vertical infrastructure, in accordance with Iowa Code section 26.14.
[ARC 3448C, IAB 11/8/17, effective 12/13/17]

761—180.2(314) Contact information. Questions regarding this chapter may be directed to the Support Services Bureau, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; telephone (515)239-1299.
[ARC 3448C, IAB 11/8/17, effective 12/13/17; ARC 5493C, IAB 3/10/21, effective 4/14/21]

761—180.3(26,314) Definitions.

“*Estimated total cost of a public improvement*” means as defined in Iowa Code section 26.2.

“*Governmental entity*” means as defined in Iowa Code section 26.2.

“*Public improvement*” means as defined in Iowa Code section 26.2.

“*Repair or maintenance work*” means as defined in Iowa Code section 26.2.

“*Responsible quotation*” means a quotation submitted by a contractor who is capable of performing the work. To be considered responsible, the contractor must possess the necessary financial and technical capability to perform the work, as well as the ability to complete the work as demonstrated by past performance or other appropriate considerations.

“*Responsive quotation*” means a quotation in which the contractor agrees to do everything required by the governmental entity’s solicitation of quotations and by the plans and specifications and other related documents, without any conditions, qualifications or exclusions.

“*Vertical infrastructure*” means buildings, all appurtenant structures, utilities, incidental street improvements including sidewalks, site development features, recreational trails, and parking facilities. Vertical infrastructure does not include any work constructed in conjunction with those matters excluded from the definition of “public improvement” in Iowa Code section 26.2(3) “b”(1) to (6).

[ARC 3448C, IAB 11/8/17, effective 12/13/17; ARC 5493C, IAB 3/10/21, effective 4/14/21]

761—180.4(314) Types of projects.

180.4(1) *Public improvement.* A public improvement involves new construction, reconstruction, or an improvement that results in betterment to a facility by improving either the original design of the facility or the function of the facility.

180.4(2) *Repair or maintenance work.* Repair or maintenance work involves work that is needed to keep or restore a facility so that it may continue to operate according to its original function or design. Repair or maintenance work may be performed by employees of a governmental entity regardless of the estimated total cost of the repair or maintenance work. If a governmental entity is unable to perform the work using its own employees, the governmental entity must follow the appropriate public improvement process set out in Iowa Code section 26.3 or 26.14, based on the estimated total cost of the work.

761—180.5(314) Solicitation of quotations.

180.5(1) A governmental entity shall solicit competitive quotations for a public improvement when the estimated total cost of the public improvement exceeds the competitive quotation threshold established in Iowa Code section 26.14, as adjusted pursuant to Iowa Code section 314.1B, but is less than the competitive bid threshold established in Iowa Code section 26.3, as adjusted pursuant to Iowa Code section 314.1B. The adjusted thresholds are published on the department’s website at www.iowadot.gov.

180.5(2) The governmental entity shall make a good-faith effort to obtain quotations for the work from at least two contractors regularly engaged in such work prior to letting a contract. Quotations shall be obtained by means of either an oral or a written solicitation directed to not less than two contractors.

180.5(3) Each solicitation shall include a description of the work to be performed, and plans and specifications for the work prepared by an architect or engineer if required by Iowa Code chapter 542B or 544A. (See 193B—Chapter 5 or rule 193C—1.5(542B) for additional guidelines.) In its solicitation, the governmental entity shall advise each contractor that it has an opportunity to inspect the work site. Each contractor requesting to inspect the work site shall be provided an equal and adequate opportunity to do so.

180.5(4) Additional information deemed pertinent by the governmental entity, or requested by a contractor, may be provided by the governmental entity if the same information is provided to all contractors from which quotations are solicited. If the information is provided in written form to a contractor, it shall be provided in the same form to all contractors from which quotations are solicited.

180.5(5) In its solicitation, the governmental entity shall:

- a. Specify the required form and content of quotations. (See rule 761—180.7(314).)
- b. Require that quotations be filed by a particular time, at a particular location and with a particular office or representative of the governmental entity.
- c. Establish the acceptable method(s) for delivery of quotations. The governmental entity may specify any or all of the following methods of delivery: mail, facsimile, electronic mail, or delivery in-hand.

180.5(6) As required by Iowa Code section 573.2, the governmental entity shall in its solicitation inform quoting contractors of the obligation of the contractor awarded the contract to provide a performance and payment bond to secure the performance and timely completion of the work and to secure the payment of subcontractors and suppliers.

180.5(7) In its solicitation, the governmental entity may require each quoting contractor to:

- a. Provide along with its quotation a quotation bond, or other quotation security or evidence of its responsibility, to assure that it will enter into a contract to perform the work and that it will provide the required performance and payment bond.
- b. Commit to the execution of a contract for the work in a form required by the governmental entity.
- c. Commit to commencement and completion dates for the work as directed by the governmental entity.
- d. File evidence of insurance, as specified by the governmental entity, with its quotation, or commit to filing such evidence of insurance upon award of the contract to perform the work.

180.5(8) In its solicitation, the governmental entity may provide that it will issue special sales tax exemption certificates to contractors and subcontractors, pursuant to Iowa Code section 423.3, subsection 80.

[ARC 3448C, IAB 11/8/17, effective 12/13/17]

761—180.6(314) Submission of competitive quotation by governmental entity. The governmental entity may itself file a competitive quotation to perform the work. The governmental entity's quotation shall be filed in the same manner as it requires quotations to be filed by contractors except as provided in subrule 180.7(3).

761—180.7(314) Form and content of competitive quotations.

180.7(1) A competitive quotation filed by a contractor or by the governmental entity shall be in writing and shall include the total price for labor, equipment, materials and supplies required to perform the work. A contractor shall not be required to include in its quotation or in individual quotation items a breakdown of costs for labor, materials, equipment and supplies. Competitive quotations filed by contractors shall include all other information, documentation or commitments required by the governmental entity in its solicitation of quotations.

180.7(2) If the governmental entity in its solicitation indicates its intention to file a competing quotation, contractors shall also separately identify in their quotations the premium cost for the required performance and payment bond and an estimate of the sales and fuel taxes they will incur in performing the work. However, if in its solicitation the governmental entity provides for the issuance of sales tax

exemption certificates to the contractor and subcontractors performing the work, quoting contractors shall not include or separately identify estimated sales tax in their quotations.

180.7(3) A quotation submitted by a governmental entity need not include the information, documents or commitments required of quoting contractors in subrule 180.5(7). A governmental entity is not required to submit a performance and payment bond.

180.7(4) The governmental entity may require that quotations from contractors be submitted on a form prescribed by the governmental entity, provided the form complies with the requirements of these rules.

761—180.8(314) Evaluation of competitive quotations.

180.8(1) If a quoting contractor does not file a quotation in the form required by the governmental entity, or does not provide all information or documentation or make all commitments required by the governmental entity, or does not sign the quotation if required by the governmental entity, the quotation shall be determined to be nonresponsive and shall be rejected by the governmental entity.

180.8(2) If the governmental entity submits a quotation to perform the work, paragraphs “a” to “c” of this subrule are applicable. If the governmental entity does not submit a quotation, these paragraphs do not apply.

a. Because the governmental entity is not required to pay sales tax or fuel tax or to submit a performance and payment bond in connection with work performed by governmental employees using governmental equipment, each contractor’s total quotation shall be adjusted to deduct the amounts identified in the quotation for estimated sales and fuel taxes and the bond premium. The amount of each contractor’s adjusted quotation shall then be compared to the amount of the quotation submitted by the governmental entity for the purpose of determining if the governmental entity’s quotation is the lowest responsive, responsible quotation.

b. If in its solicitation the governmental entity provides for the issuance of sales tax exemption certificates to the contractor and subcontractors performing the work, quoting contractors shall not include or separately identify estimated sales tax in their quotations, and the governmental entity shall not deduct estimated sales tax from the contractors’ quotations for the purpose of determining if the governmental entity’s quotation is the lowest responsive, responsible quotation.

c. The governmental entity may require the contractor to which the work is awarded to provide documentation of the premium cost incurred by it for the performance and payment bond and of all sales and fuel taxes paid by it and its subcontractors in connection with the work. The governmental entity may decline to pay the amounts identified by the contractor in its quotation for the bond premium and estimated sales and fuel taxes if these amounts are not properly documented as having been paid.

761—180.9(314) Award of contract and subsequent procedures.

180.9(1) Except as provided in subrule 180.9(3), the governmental entity shall award the contract for the work to the contractor submitting the lowest responsive, responsible quotation, subject to Iowa Code section 26.9, or the governmental entity may reject all of the quotations. A contract shall be considered awarded when the governmental entity unconditionally accepts and approves the lowest responsive, responsible quotation. The governing body of the governmental entity shall record the approved quotation in its meeting minutes.

180.9(2) The governing body of a governmental entity may delegate the authority to award and execute contracts, or to award contracts and authorize the work to proceed, to an officer or employee of the governmental entity, provided that an award approved outside a meeting of the governing body shall be reported in the meeting minutes of the next regular meeting of the governing body.

180.9(3) If no quotations are received from contractors to perform the work or if the governmental entity’s estimated cost to do the work with its employees, as reflected in its quotation, is less than the lowest responsive, responsible quotation received from a contractor, the governmental entity may authorize its employees to perform the work.

180.9(4) Upon the submission of the required performance and payment bond by the contractor to which the contract has been awarded and upon approval of the bond by the governmental entity, the

governmental entity shall execute a contract to perform the work or shall authorize the contractor to proceed with the work.

180.9(5) Upon execution of the contract by the contractor and the governmental entity or upon authorization to proceed by the governmental entity and acknowledgment thereof by the contractor, the governmental entity shall release the quotation bonds or other quotation security submitted with the quotations received.

180.9(6) If the governmental entity is a city and the cost of the work will exceed the amount provided for in Iowa Code section 380.4, the governing body is required to pass a resolution approving the expenditure.

761—180.10(314) Retained funds. In addition to requiring the contractor to submit a performance and payment bond, the governmental entity shall also retain funds from each payment to the contractor for the benefit of subcontractors and suppliers, and apply or release such funds, as required by Iowa Code chapter 573.

[ARC 4342C, IAB 3/13/19, effective 4/17/19]

These rules are intended to implement Iowa Code sections 26.2, 26.14, 314.1A, 314.1B, 573.2, and 573.28.

[Filed 4/16/07, Notice 2/28/07—published 5/9/07, effective 6/13/07]

[Filed ARC 3448C (Notice ARC 3269C, IAB 8/30/17), IAB 11/8/17, effective 12/13/17]

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[Filed ARC 5493C (Notice ARC 5375C, IAB 1/13/21), IAB 3/10/21, effective 4/14/21]

MOTOR CARRIERS
CHAPTER 500
INTERSTATE REGISTRATION AND OPERATION OF VEHICLES
[Prior to 6/3/87, Transportation Department[820]—(07.F) Ch 1]

761—500.1(326) Definitions. The definitions in Iowa Code sections 326.2 and 326.3 apply to this chapter. In addition:

“*Distance schedule*” means the department form used to report fleet distance.

“*IRP*” means the International Registration Plan as defined in Iowa Code section 326.2.

“*Qualified registrant*” means a motor carrier who has received written approval by the department to self-certify IRP credential destruction.

“*Self-certification of IRP credential destruction*” means a signed statement that is completed by a qualified registrant certifying the date the IRP credentials have been destroyed.

“*Temporary evidence of apportioned registration*” means a document issued by the department that describes the vehicle and lists the weight for each jurisdiction in which the vehicle is registered for operation and allows the vehicle to be operated.

“*Vehicle schedule*” means the department form used to report vehicle registration information.

This rule is intended to implement Iowa Code sections 326.2, 326.3, 326.15 and 326.33.

[ARC 5494C, IAB 3/10/21, effective 4/14/21]

761—500.2(17A,326) General information.

500.2(1) Information and location. Applications, forms and information on interstate registration and operation of vehicles are available on the department’s website at www.iowadot.gov, by mail from the Vehicle and Motor Carrier Services Bureau, Iowa Department of Transportation, P.O. Box 10382, Des Moines, Iowa 50306-0382; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (515)237-3268; by facsimile at (515)237-3225; or by email at omcs@iowadot.us.

500.2(2) Method of operation. The operations of the department’s motor vehicle division relating to reciprocity and apportioned registration shall be conducted in accordance with the IRP and Iowa Code chapters 321 and 326.

500.2(3) Organizational data. The vehicle and motor carrier services bureau of the motor vehicle division is authorized pursuant to Iowa Code chapter 326 to:

a. Enter into reciprocity apportioned registration agreements with other jurisdictions. The department is a member of the IRP. The IRP and any revisions thereto are hereby incorporated into this chapter. A copy of the agreement may be obtained by contacting the vehicle and motor carrier services bureau or at www.irponline.org. Under this agreement, the vehicle and motor carrier services bureau shall do all of the following:

(1) Compute and collect apportionable fees due this state under apportioned registration agreements.

(2) Issue registration plates, validation stickers, cab cards, temporary evidence of apportioned registration, and trip permits to qualified registrants.

(3) Enter into reciprocity agreements with other jurisdictions. These agreements exempt nonresidents from the registration and registration fee requirements of Iowa Code chapter 321.

This rule is intended to implement Iowa Code sections 17A.3, 326.5 and 326.6.

[ARC 5494C, IAB 3/10/21, effective 4/14/21]

761—500.3(17A,326) Waiver of rules. In accordance with 761—Chapter 11, the director of transportation may, in response to a petition, waive provisions of this chapter. A waiver shall not be granted unless the director finds that special or emergency circumstances exist. “Special or emergency circumstances” means one or more of the following:

500.3(1) Circumstances where the movement is necessary to cooperate with cities, counties, other state agencies or other states in response to a national or other disaster.

500.3(2) Circumstances where the movement is necessary to cooperate with national defense officials.

500.3(3) Circumstances where the movement is necessary to cooperate with public or private utilities in order to maintain their public services.

500.3(4) Circumstances where the movement is essential to ensure safety and protection of any person or property due to events such as, but not limited to, pollution of natural resources, a potential fire or explosion.

500.3(5) Circumstances where weather or transportation problems create an undue hardship for citizens of the state of Iowa.

500.3(6) Circumstances where movement involves emergency-type vehicles.

500.3(7) Uncommon or extraordinary circumstances where the movement is essential to the existence of an Iowa business and the move may be accomplished without causing undue hazard to the safety of the traveling public or undue damage to private or public property.

This rule is intended to implement Iowa Code sections 17A.9A and 326.33.

761—500.4(326) Renewal for IRP registration. Renewal reminder notices are sent electronically or by mail at least 60 days prior to the registration expiration date to all registrants who maintained an active IRP fleet with Iowa during that year. A registrant may request a renewal reminder notice to be sent by mail. The renewal is made available online at least 60 days prior to the registration expiration date and can be accessed on the department's website.

500.4(1) The renewal must include:

a. A completed and signed distance schedule and vehicle schedule(s). The schedules can be filed and signed either electronically or on paper.

b. Title documentation, if necessary.

c. One of the following:

(1) Received federal heavy vehicle use tax (Form 2290 Schedule 1) for vehicles with a taxable gross weight of 55,000 pounds or more.

(2) A copy of Form 2290 Schedule 1 and sufficient documentation of payment of the tax due at the time Form 2290 was filed. The documentation can include, but is not limited to, a photocopy of both sides of a canceled check, a bank statement indicating the amount of tax paid and electronic acknowledgment indicating a payment of tax, and an Internal Revenue Service printout of the taxpayer's account showing the amount of tax paid.

500.4(2) Additional renewal procedures.

a. Vehicles may be deleted from the fleet at the time of renewal. Operating a vehicle with credentials marked as deleted shall result in the registrant being responsible for any fees assessed including any applicable penalty. Operating a vehicle with credentials that were self-certified as destroyed shall result in suspension of the self-certification privilege.

b. Units being stored shall be marked "stored" on the renewal vehicle schedule and the plates, cab cards and validation stickers must be returned in accordance with rule 761—500.5(321).

c. Vehicles may be added at the time of renewal. Upon payment of required fees, an applicant must apply for a temporary evidence of apportioned registration to be issued to operate a vehicle in accordance with the IRP. The department may extend the temporary evidence of apportioned registration if there are extenuating circumstances beyond the applicant's control.

d. When the registrant is seeking a refund in accordance with Iowa Code section 326.15 for vehicles deleted at the time of renewal, the annual and permanent registration plates and validation stickers must be returned to the vehicle and motor carrier services bureau.

This rule is intended to implement Iowa Code sections 326.6, 326.11, 326.12, 326.14 and 326.15.
[ARC 5494C, IAB 3/10/21, effective 4/14/21]

761—500.5(321) Deadline for placing a vehicle in storage. The registrant of a currently registered vehicle may at any time request that a vehicle be put into storage. The registrant must complete a vehicle schedule and return it with the plate, cab card and validation sticker to the vehicle and motor carrier services bureau. The vehicle schedule, plate, cab card and sticker must be received or postmarked on or before the registration expiration date to stop the registration fee from being assessed for the renewal

year. The vehicle and motor carrier services bureau shall destroy the plate and return the cab card to the registrant with the word “stored” stamped on it. Placing the vehicle in storage stops penalties on registration fees. When the vehicle is taken out of storage, the vehicle shall be assessed for the current annual registration fee.

This rule is intended to implement Iowa Code sections 321.126 and 321.134.
[ARC 5494C, IAB 3/10/21, effective 4/14/21]

761—500.6(321,326) Payment, delinquency and suspension.

500.6(1) Payment shall be made payable to the Iowa Department of Transportation by cash, check, credit card, or any other means offered by the department. Payment shall be due 30 calendar days from the invoice date. However, renewal invoices shall be due 30 calendar days from the invoice date or by the last day of the registration expiration month, whichever is later.

500.6(2) Invoices not paid by the due date shall be assessed a late payment penalty as provided in Iowa Code sections 326.14 and 326.16. The same penalty amount will be assessed the first of each month thereafter until the total invoice and all penalties are paid in full.

500.6(3) A delinquency notice shall be sent on invoices 30 calendar days overdue. The department shall send a delinquency notice stating the IRP registration shall be suspended unless payment is received within 30 calendar days from the date of the delinquency notice. If payment is not received in a timely manner, a notice of suspension shall be sent to the registrant. When a registrant is under suspension, all of the registrant’s Iowa-based IRP vehicles shall be suspended.

This rule is intended to implement Iowa Code sections 326.10A, 326.14 and 326.16.
[ARC 5494C, IAB 3/10/21, effective 4/14/21]

761—500.7(326) Self-certification of IRP registration plate and validation sticker destruction.

500.7(1) In order to request a refund for unused registration fees, unless the registrant qualifies to self-certify destruction under this rule, plates and validation stickers must be returned to the department when a vehicle is deleted from the fleet. A registrant must meet all of the following requirements to qualify for department approval to self-certify destruction of IRP credentials:

- a. A minimum of five years’ experience with IRP registration.
- b. A satisfactory IRP payment history. A satisfactory payment history includes, but is not limited to, no suspension of IRP registration in the last five years due to late payment or returned check because of insufficient funds.
- c. A satisfactory rating from the U.S. Department of Transportation in the previous five years.

500.7(2) A motor carrier subject to a federal out-of-service order in the current year or any of the four prior years shall not be eligible to self-certify IRP credential destruction.

This rule is intended to implement Iowa Code section 326.15.
[ARC 5494C, IAB 3/10/21, effective 4/14/21]

761—500.8(326) IRP credentials. Upon payment of appropriate fees and submission of all required documentation, the vehicle and motor carrier services bureau shall issue one IRP plate for each power unit to be mounted on the front of the power unit, one trailer plate to be mounted on the rear of the trailer, and one cab card for each power unit. The cab card may be in either a physical or electronic format.

This rule is intended to implement Iowa Code section 326.14.
[ARC 5494C, IAB 3/10/21, effective 4/14/21]

761—500.9(326) Nonrenewal vehicle additions. A registrant may add a vehicle to the fleet at any time after the commencement of the registration year. Upon payment of required fees, temporary evidence of apportioned registration may be issued to operate the vehicle(s). The temporary evidence of apportioned registration shall not exceed 45 days. However, the department may extend the temporary evidence of apportioned registration for up to a total of 60 days if there are extenuating circumstances. Once temporary evidence of apportioned registration is issued and used, fees shall be due and the invoice may

only be canceled if an error was made by the department or there were extenuating circumstances for which nonuse can be proven.

This rule is intended to implement Iowa Code section 326.11.
[ARC 5494C, IAB 3/10/21, effective 4/14/21]

761—500.10(326) Nonrenewal vehicle deletions. A registrant may delete vehicles from the fleet at any time after the commencement of the registration year. The plates and validation stickers must be returned to the vehicle and motor carrier services bureau at the time of deletion. In lieu of returning the plates and validation stickers, a qualified registrant under rule 761—500.7(326) may submit a self-certification of IRP credential destruction on or before the vehicle(s) deletion date to the vehicle and motor carrier services bureau. Operating a vehicle with credentials that were self-certified as destroyed shall result in suspension of the self-certification privilege, and the registrant shall be responsible for any additional fees that would have been due beyond the stated destruction date.

This rule is intended to implement Iowa Code sections 326.12 and 326.15.
[ARC 5494C, IAB 3/10/21, effective 4/14/21]

761—500.11(326) Voluntary cancellation of registration. A registrant may cancel an application for IRP registration if the registrant notifies the vehicle and motor carrier services bureau within 15 days of the invoice date. The notice shall state the reason for cancellation, the licensing status and ownership and be signed by the registrant or its representative. If notice is not received within 15 days or if a temporary evidence of apportioned registration was issued in accordance with 761—500.9(326), all registration fees must be paid in full.

This rule is intended to implement Iowa Code sections 326.6 and 326.11.
[ARC 5494C, IAB 3/10/21, effective 4/14/21]

761—500.12(326) Policy on registration credit. If a vehicle is deleted from the IRP fleet and replaced with another vehicle, registration credit may be applied to IRP fees due on the replacement vehicle. The vehicle schedule identifying the added and deleted vehicles must be submitted to the vehicle and motor carrier services bureau. The deletion must take place on or before the effective date of the replacement vehicle's registration. Allowance for credit of deleted vehicles shall be subject to the conditions set forth in Iowa Code section 326.12.

This rule is intended to implement Iowa Code section 326.12.
[ARC 5494C, IAB 3/10/21, effective 4/14/21]

761—500.13(326) Penalty for late filing of vehicle schedule.

500.13(1) As provided in Iowa Code sections 326.14 and 326.16, a late filing penalty of 5 percent shall be assessed to the vehicle if a vehicle schedule is not filed within 30 days of:

- a. The purchase of a new or used vehicle;
- b. The date a vehicle is brought across state borders into Iowa to be registered; or
- c. A vehicle being first operated with the exemption allowed under Iowa Code section 321.20A.

500.13(2) An additional penalty shall be assessed on the first of each month thereafter until the vehicle schedule is filed.

500.13(3) The department may collect intrastate registration fees and penalties when registering a delinquent vehicle to bring the vehicle fees current before allowing the IRP registration of the vehicle.

This rule is intended to implement Iowa Code sections 321.20A, 326.11, 326.14 and 326.16.
[ARC 5494C, IAB 3/10/21, effective 4/14/21]

761—500.14(326) Renewal and vehicle schedule late payment penalty. Rescinded ARC 5494C, IAB 3/10/21, effective 4/14/21.

761—500.15(321) Deadline for payment of first-half fee. Rescinded ARC 5494C, IAB 3/10/21, effective 4/14/21.

761—500.16(321,326) Second-half late payment penalty. Rescinded **ARC 5494C**, IAB 3/10/21, effective 4/14/21.

761—500.17(326) Duplicate credentials. The fees for duplicate credentials are as follows:

500.17(1) A replacement cab card is \$3.

500.17(2) A replacement plate including the cab card is \$8.

500.17(3) If applicable, a mailing fee will also be assessed based on the number of plates or cab cards being issued.

This rule is intended to implement Iowa Code section 326.22.
[ARC 5494C, IAB 3/10/21, effective 4/14/21]

761—500.18(326) Suspension for nonpayment of registration fees. Rescinded **ARC 5494C**, IAB 3/10/21, effective 4/14/21.

761—500.19(326) Suspension of registration if payment is dishonored by a financial institution. Rescinded **ARC 5494C**, IAB 3/10/21, effective 4/14/21.

761—500.20(326) Making claim for refund. A refund of Iowa fees previously paid for the registration of vehicles may be made in accordance with Iowa Code sections 321.126, 321.127, 321.129 and 326.15. A claim for refund form may be obtained from the vehicle and motor carrier services bureau. In lieu of returning the plates, a qualified registrant may submit a self-certification of IRP credential destruction on or before the vehicle's deletion date to the vehicle and motor carrier services bureau.

This rule is intended to implement Iowa Code sections 321.126, 321.127, 321.129 and 326.15.
[ARC 5494C, IAB 3/10/21, effective 4/14/21]

761—500.21(326) Registration expiration and enforcement dates. Rescinded **ARC 5494C**, IAB 3/10/21, effective 4/14/21.

761—500.22(326) Registration of vehicles with non-Iowa titles. Registrants applying for registration for non-Iowa titled vehicles shall submit to the vehicle and motor carrier services bureau with the application or payment as specified in rule 761—500.7(326) either a copy of the non-Iowa title or a copy of the title application if the title has not been issued. If a jurisdiction does not issue titles, a copy of the bill of sale or a copy of the Canadian registration shall accompany the application or payment.

This rule is intended to implement Iowa Code section 326.11.
[ARC 5494C, IAB 3/10/21, effective 4/14/21]

761—500.23(326) Record retention.

500.23(1) Record retention requirement and penalty. Iowa IRP registrants shall preserve the records upon which their registration is based as required by the IRP for the current registration year and the three preceding registration years. On request, the registrant shall make such records available for audit. The department may assess a penalty upon registrants who have failed to maintain proper records.

500.23(2) Adequacy of records. The records maintained by a registrant shall be adequate to enable the department to verify the distances reported in the registrant's application for apportioned registration and to evaluate the accuracy of the registrant's distance accounting system. The records may be produced through any means and retained in any format or medium available to the registrant and accessible by the department.

a. The following records produced by a means other than a vehicle-tracking system shall be considered adequate:

- (1) The beginning and ending dates of the trip to which the records pertain.
- (2) The origin and destination of the trip.
- (3) The route of travel.
- (4) The beginning and ending reading from the odometer, hubodometer, engine control module (ECM), or any similar device for the trip.
- (5) The total distance of the trip.

- (6) The distance traveled in each jurisdiction.
- (7) The vehicle identification number or vehicle unit number.
- b.* The following records produced wholly or partly by a vehicle-tracking system, including a system based on a global positioning system (GPS) shall be considered adequate under this subrule:
 - (1) The original GPS or other location data for the vehicle to which the records pertain.
 - (2) The date and time of each GPS reading or other system reading.
 - (3) The location of each GPS reading or other system reading.
 - (4) The beginning and ending reading from the odometer, hubodometer, engine control module (ECM), or any similar device for the period to which the records pertain.
 - (5) The calculated distance between each GPS reading or other system reading.
 - (6) The route of the vehicle's travel.
 - (7) The total distance traveled by the vehicle.
 - (8) The distance traveled in each jurisdiction.
 - (9) The vehicle identification number or vehicle unit number.

500.23(3) Summaries. The following summaries shall be maintained:

a. A summary of the fleet's operations of each month, which includes both the full distance traveled by each apportioned vehicle in the fleet during the calendar month and the distance traveled in the month by each apportioned vehicle in each jurisdiction.

b. A summary of the fleet's operations for each calendar quarter, which includes both the full distance traveled by vehicles in the fleet during the calendar quarter and the distance traveled in each jurisdiction by the vehicles in the fleet during the calendar quarter.

This rule is intended to implement Iowa Code section 326.19A.

[ARC 5494C, IAB 3/10/21, effective 4/14/21]

761—500.24(326) Trip permits. The registrants may meet the registration requirements of Iowa Code chapter 326 by operating under a trip permit. However, moves that are intrastate or exceed legal dimensions or weight and operate under permit as specified in Iowa Code chapter 321E shall not be allowed.

500.24(1) Trip permits may be obtained through the department's website, by mail, or in person from the vehicle and motor carrier services bureau. Such requests shall include the appropriate permit fee remittance.

500.24(2) Registrants purchasing trip permits in advance of use may not return unused permits for a refund.

This rule is intended to implement Iowa Code sections 326.23 and 326.46.

[ARC 5494C, IAB 3/10/21, effective 4/14/21]

761—500.25(326) Electronic information. To the greatest extent possible, the vehicle and motor carrier services bureau shall maintain in electronic form all records required under this chapter. The retention period for electronic records must follow the guidelines of the IRP.

500.25(1) IRP vehicle transaction. The vehicle and motor carrier services bureau shall destroy paper copies of IRP vehicle transaction requests 90 days after the IRP invoice is generated.

500.25(2) Federal heavy use tax (Form 2290 Schedule 1). The vehicle and motor carrier services bureau shall maintain Form 2290 Schedule 1 in accordance with 23 CFR Section 669.9.

This rule is intended to implement Iowa Code section 326.33.

[ARC 5494C, IAB 3/10/21, effective 4/14/21]

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¹ Effective date of 500.1, definition of “Power unit,” 500.2, 500.3(1), 500.3(3), introductory paragraph, 500.3(3) “a” and “c,” 500.3(4) “a,” introductory paragraph, 500.3(4) “c,” 500.3(5) “a,” introductory paragraph, 500.3(5) “a”(2), 500.3(5) “b”(2), 500.3(6), 500.6 to 500.9, 500.11, 500.12, 500.14, 500.17, 500.20, June 2, 1993, delayed 70 days by the Administrative Rules Review Committee at its meeting held May 12, 1993; delay lifted by this Committee June 8, 1993, effective June 9, 1993.

CHAPTER 602
CLASSES OF DRIVER'S LICENSES

761—602.1(321) Driver's licenses.

602.1(1) *Classes.* The department issues the following classes of driver's licenses. All licenses issued, including special licenses and permits, shall carry a class designation. A license shall be issued for only one class, except that Class M may be issued in combination with another class.

- Class A—commercial driver's license (CDL)
- Class B—commercial driver's license (CDL)
- Class C—commercial driver's license (CDL)
- Class C—noncommercial driver's license
- Class D—noncommercial driver's license (chauffeur)
- Class M—noncommercial driver's license (motorcycle)

602.1(2) *Special licenses and permits.* The department issues the following special licenses and permits. More than one type of special license or permit may be issued to an applicant. On the driver's license, a restriction number designates the type of special license or permit issued, as follows:

- 1—Motorcycle instruction permit—includes motorcycle instruction permits issued under Iowa Code subsections 321.180(1) and 321.180B(1)
- 2—Noncommercial instruction permit (vehicle less than 16,001 gross vehicle weight rating)—includes instruction permits, other than motorcycle instruction permits, issued under Iowa Code subsection 321.180(1), section 321.180A and subsection 321.180B(1)
- 3—Commercial learner's permit
- 4—Chauffeur's instruction permit
- 5—Motorized bicycle license
- 6—Minor's restricted license
- 7—Minor's school license

602.1(3) *Commercial driver's license (CDL).* See 761—Chapter 607 for information on the procedures, requirements and validity of a commercial driver's license (Classes A, B and C) and a commercial learner's permit, and their restrictions and endorsements.

This rule is intended to implement Iowa Code sections 321.178, 321.180, 321.180A, 321.180B, 321.189, and 321.194.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2644C, IAB 8/3/16, effective 9/7/16]

761—602.2(321) Information and forms. Applications, forms and information about driver's licensing are available at any driver's license service center. Assistance is also available by mail from the Driver and Identification Services Bureau, Iowa Department of Transportation, P.O. Box 9204, Des Moines, Iowa 50306-9204; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (515)244-8725; by facsimile at (515)239-1837; or on the department's website at www.iowadot.gov.

602.2(1) *Certificate of completion.* Proof of successful completion of an Iowa-approved course in driver education, motorcycle rider education, or motorized bicycle education shall be submitted to the department on Form 430036 or through an online reporting system used by participating Iowa-approved driver education, motorcycle rider education, or motorized bicycle rider education providers.

a. If a student completed a course in another state, a public or licensed commercial or private provider of the Iowa-approved course may issue the form or online completion, if applicable, for the student if the provider determines that the out-of-state course is comparable to the Iowa-approved course.

b. If the out-of-state course is comparable but lacks certain components of the Iowa-approved course, the provider may issue the form or online completion, if applicable, after the student completes the missing components.

602.2(2) *Affidavit for school license.* Form 430021 shall be used for submitting the required statements, affidavits and parental consent for a minor's school license. See rule 761—602.26(321).

602.2(3) *Waiver of accompanying driver for intermediate licensee.* Form 431170 is the waiver described in Iowa Code subsection 321.180B(2). This form allows an intermediate licensee to drive

unaccompanied between the hours of 12:30 a.m. and 5 a.m. and must be in the licensee's possession when the licensee is driving during the hours to which the waiver applies.

a. If the waiver is for employment, the form must be signed by the licensee's employer.

b. If the licensee attends a public school and the waiver is for school-related extracurricular activities, the form must be signed by the chairperson of the school board, the superintendent of the school, or the principal of the school if authorized by the superintendent. If the licensee attends an accredited nonpublic school and the waiver is for school-related extracurricular activities, the form must be signed by an authority in charge of the accredited nonpublic school or a duly authorized representative of the authority.

c. The form must be signed by the licensee's parent or guardian. However, the parent's or guardian's signature is not required if the licensee is married and the original or a certified copy of the marriage certificate is in the licensee's possession when the licensee is driving during the hours to which the waiver applies.

602.2(4) Passenger restriction for intermediate licensee. The passenger restriction required by Iowa Code section 321.180B(2) will be added to an intermediate license unless waived by the licensee's parent or guardian at the time the license is issued. If the restriction is not waived at the time the license is issued, the intermediate license will be designated with a "9" restriction with the following notation: "Only 1 unrelated minor passenger allowed until [six months from the date the license is issued]." The licensee must obey the restriction for the first six months after the intermediate license is issued. If a parent or guardian wishes to waive the passenger restriction after the license has already been issued, the licensee and the parent or guardian must apply for a duplicate license and pay the replacement fee pursuant to 761—subrule 605.11(4).

This rule is intended to implement Iowa Code sections 321.8, 321.178, 321.180B, 321.184, 321.189, and 321.194.

[ARC 7902B, IAB 7/1/09, effective 8/5/09; ARC 2644C, IAB 8/3/16, effective 9/7/16; ARC 4271C, IAB 1/30/19, effective 3/6/19; ARC 4759C, IAB 11/6/19, effective 12/11/19; ARC 4851C, IAB 1/1/20, effective 2/5/20; ARC 5204C, IAB 10/7/20, effective 11/11/20; ARC 5258C, IAB 11/4/20, effective 12/9/20]

761—602.3(321) Examination and fee. Rescinded IAB 8/9/00, effective 7/24/00.

761—602.4(321) Definitions of immediate family.

602.4(1) A "member of the permittee's immediate family" as used in Iowa Code subsection 321.180(1) means the permittee's parent or guardian or a brother, sister or other relative of the permittee who resides at the permittee's residence.

602.4(2) A "member of the permittee's immediate family" as used in Iowa Code section 321.180B, subsections 1 and 2, means a brother, sister or other relative of the permittee who resides at the permittee's residence.

This rule is intended to implement Iowa Code sections 321.180 and 321.180B.

761—602.5 to 602.10 Reserved.

761—602.11(321) Class C noncommercial driver's license. This rule describes a noncommercial Class C driver's license that is not a special license or permit.

602.11(1) Validity and issuance.

a. The license is valid for operating:

(1) A motor vehicle, including an autocycle as defined in Iowa Code section 321.1, that does not require a commercial driver's license or a Class D driver's license for its operation.

(2) A motorized bicycle.

(3) A motorcycle only if the license has a motorcycle endorsement.

b. The license is issued for either two years or eight years.

(1) A qualified applicant who is at least 17 years, 11 months of age but not yet 78 years of age shall be issued an eight-year license. However, the expiration date of the license issued shall not exceed the licensee's 80th birthday.

(2) A two-year license shall be issued to a qualified applicant who is under 17 years, 11 months of age or who is 78 years of age or older.

(3) A two-year license may also be issued, at the discretion of the department, to an applicant whose license is restricted due to vision or other physical disabilities.

602.11(2) Requirements.

a. An applicant shall be at least 16 years of age.

b. Except as otherwise provided in Iowa Code subsection 321.178(3), an applicant under 18 years of age must meet the requirements of Iowa Code section 321.180B and submit proof of successful completion of an Iowa-approved course in driver education.

c. For purposes of determining eligibility for an intermediate license issued to a person 16 or 17 years of age under Iowa Code subsection 321.180B(2):

(1) The 12-month period during which the applicant is required to possess an instruction permit before applying for an intermediate license shall be calculated cumulatively and shall include any period of time during which the applicant has held a valid instruction permit issued under Iowa Code subsection 321.180B(1), a minor's school license issued under Iowa Code section 321.194, or comparable instruction permit or license issued by another state, but shall exclude any period of time during which the permit or license is suspended, revoked, or canceled, or the applicant otherwise did not have a valid driving privilege.

(2) The six-month period during which the applicant is required to remain accident and violation free shall be calculated continuously and must encompass without interruption the six-month period of time immediately preceding the application. The applicant must hold a valid instruction permit issued under Iowa Code subsection 321.180B(1), a minor's school license issued under Iowa Code section 321.194, or a comparable instruction permit or license issued by another state and maintain a valid driving privilege without interruption throughout the continuous six-month period.

d. For purposes of determining eligibility for a full license issued to a person 17 years of age under Iowa Code subsection 321.180B(4), the 12-month period during which the applicant is required to possess an intermediate license and to remain accident and violation free before applying for a full license shall be calculated together and continuously and must encompass without interruption the 12-month period of time immediately preceding the application. The applicant must hold a valid intermediate license issued under Iowa Code subsection 321.180B(2) or a comparable license issued by another state and maintain a valid driving privilege without interruption throughout the continuous 12-month period.

This rule is intended to implement Iowa Code sections 321.1, 321.177, 321.178, 321.180B, 321.189 and 321.196.

[ARC 1714C, IAB 11/12/14, effective 12/17/14; ARC 2644C, IAB 8/3/16, effective 9/7/16; ARC 2985C, IAB 3/15/17, effective 4/19/17; ARC 5495C, IAB 3/10/21, effective 4/14/21]

761—602.12(321) Class D noncommercial driver's license (chauffeur). This rule describes a noncommercial Class D driver's license.

602.12(1) Validity and issuance.

a. The license is valid for operating:

(1) A motor vehicle as a chauffeur as specified by the endorsement on the license, unless the type of vehicle or type of operation requires a commercial driver's license.

(2) A motor vehicle that may be legally operated under a noncommercial Class C driver's license, including a motorized bicycle.

(3) A motorcycle only if the license has a motorcycle endorsement.

b. The license shall have one endorsement authorizing a specific type of motor vehicle or type of operation, as listed in 761—subrule 605.7(3). The gross vehicle weight rating shall be determined pursuant to rule 761—604.35(321).

c. The license is issued for either two years or eight years.

(1) A qualified applicant who is at least 18 years of age but not yet 78 years of age shall be issued an eight-year license. However, the expiration date of the license issued shall not exceed the licensee's 80th birthday.

- (2) A two-year license shall be issued to a qualified applicant who is 78 years of age or older.
- (3) A two-year license may also be issued, at the discretion of the department, to an applicant whose license is restricted due to vision or other physical disabilities.

602.12(2) Requirements.

- a. An applicant shall be at least 18 years of age.
- b. Reserved.

This rule is intended to implement Iowa Code sections 321.1, 321.177, 321.189, and 321.196. [ARC 1714C, IAB 11/12/14, effective 12/17/14; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 4586C, IAB 7/31/19, effective 9/4/19; ARC 5495C, IAB 3/10/21, effective 4/14/21]

761—602.13(321) Class M noncommercial driver's license (motorcycle). This rule describes a noncommercial Class M driver's license that is not a special license or permit.

602.13(1) Validity and issuance.

- a. The license is valid for operating:
 - (1) A motorcycle. However, the license may have a restriction which limits operation to a three-wheel motorcycle.
 - (2) A motorized bicycle.
- b. The license is issued for either two years or eight years.
 - (1) A qualified applicant who is at least 17 years, 11 months of age but not yet 78 years of age shall be issued an eight-year license. However, the expiration date of the license issued shall not exceed the licensee's 80th birthday.
 - (2) A two-year license shall be issued to a qualified applicant who is under 17 years, 11 months of age or who is 78 years of age or older.
 - (3) A two-year license may also be issued, at the discretion of the department, to an applicant whose license is restricted due to vision or other physical disabilities.

c. An Iowa driver's license issued before March 15, 1968, which is still valid because of an extension, is valid for motorcycles. An Iowa driver's license issued from March 15, 1968, through June 30, 1972, which is still valid because of an extension, is valid for motorcycles unless the back of the license is stamped "Not valid for motorcycles."

602.13(2) Requirements.

- a. An applicant shall be at least 16 years of age.
- b. Except as otherwise provided in Iowa Code subsection 321.178(3), an applicant under 18 years of age must meet the requirements of Iowa Code section 321.180B and submit proof of successful completion of an Iowa-approved course in driver education.
- c. An applicant under 18 years of age must submit proof of successful completion of an Iowa-approved course in motorcycle rider education.

This rule is intended to implement Iowa Code sections 321.177, 321.178, 321.180B, 321.189 and 321.196.

[ARC 1714C, IAB 11/12/14, effective 12/17/14; ARC 5495C, IAB 3/10/21, effective 4/14/21]

761—602.14(321) Transition from five-year to eight-year licenses. During the period January 1, 2014, to December 31, 2018, the department shall issue qualified applicants otherwise eligible for an eight-year license a five-year, six-year, seven-year, or eight-year license, subject to all applicable limitations for age and ability. The applicable period shall be randomly assigned to the applicant by the department's computerized issuance system based on a distribution formula intended to spread renewal volumes as equally as practical over the eight-year period beginning January 1, 2019, and ending December 31, 2026.

This rule is intended to implement Iowa Code section 321.196.

[ARC 1714C, IAB 11/12/14, effective 12/17/14; ARC 4271C, IAB 1/30/19, effective 3/6/19]

761—602.15(321) Minor's restricted license. Renumbered as 761—602.25(321)IAB 1/8/92, effective 2/12/92.

761—602.16(321) Temporary instruction permit. Rescinded IAB 1/8/92, effective 2/12/92.

761—602.17(321) Minor's school license. Renumbered as 761—602.26(321)IAB 1/8/92, effective 2/12/92.

761—602.18(321) Motorcycle instruction permit. This rule describes a motorcycle instruction permit issued under Iowa Code subsection 321.180(1) or 321.180B(1).

602.18(1) Validity and issuance.

- a. The motorcycle instruction permit is a permit that is added to another driver's license.
- b. The permit is valid for operating a motorcycle when the permittee is accompanied by a person specified in Iowa Code subsection 321.180(1) or 321.180B(1), as applicable to the age of the permittee.
- c. The permit is not valid for operating a motorized bicycle.
- d. The permit is issued for four years and is not renewable.

602.18(2) Requirement. An applicant shall be at least 14 years of age.

This rule is intended to implement Iowa Code sections 321.177, 321.180 and 321.180B.

761—602.19(321) Noncommercial instruction permit. This rule describes a noncommercial instruction permit, other than a motorcycle instruction permit, issued under Iowa Code subsection 321.180(1) or 321.180B(1).

602.19(1) Validity and issuance.

- a. The permit is a restricted, noncommercial Class C driver's license.
- b. The permit is valid for operating a motor vehicle that may be legally operated under a noncommercial Class C driver's license when the permittee is accompanied by a person specified in Iowa Code subsection 321.180(1) or 321.180B(1), as applicable to the age of the permittee.
- c. The permit is not valid for operating a motorized bicycle.
- d. The permit is not valid as a motorcycle instruction permit.
- e. The permit is issued for four years.

602.19(2) Requirement. An applicant shall be at least 14 years of age.

This rule is intended to implement Iowa Code sections 321.177, 321.180 and 321.180B.

761—602.20 Rescinded IAB 11/18/98, effective 12/23/98.

761—602.21(321) Special noncommercial instruction permit. This rule describes a special noncommercial instruction permit issued under Iowa Code section 321.180A.

602.21(1) Validity and issuance.

- a. The permit is a restricted, noncommercial Class C driver's license that is issued to a person whose application for driver's license renewal has been denied or whose driver's license has been suspended for incapability due to a physical disability.
- b. The permit is valid for operating a motor vehicle that may be legally operated under a noncommercial Class C driver's license when the permittee is accompanied by a person specified in Iowa Code section 321.180A.
- c. The permit is not valid for operating a motorized bicycle.
- d. The permit is not valid as a motorcycle instruction permit.
- e. The permit is valid for six months from the date of issuance. It is invalid after the expiration date on the permit.
- f. The permit may be reissued for one additional six-month period.

602.21(2) Requirement. An applicant must submit a medical report as referenced in 761—subrule 605.4(6).

This rule is intended to implement Iowa Code section 321.180A.

[ARC 4586C, IAB 7/31/19, effective 9/4/19]

761—602.22 Reserved.

761—602.23(321) Chauffeur's instruction permit.**602.23(1) Validity and issuance.**

a. A chauffeur's instruction permit is a permit that is added to a Class D license or a noncommercial Class C license that is not a special license or permit.

b. The license with the permit is valid for operating:

(1) A motor vehicle that may be legally operated under the class of license (and for Class D, the endorsement) held by the licensee, including a motorized bicycle.

(2) A motor vehicle, other than a commercial motor vehicle or a motorcycle, as a chauffeur if accompanied by a person with a valid Class D license or a commercial driver's license valid for the vehicle being operated.

c. The permit is issued for two years.

602.23(2) Requirements.

a. An applicant shall be at least 18 years of age.

b. Reserved.

This rule is intended to implement Iowa Code sections 321.1, 321.177 and 321.180.

761—602.24(321) Motorized bicycle license.**602.24(1) Validity and issuance.**

a. A motorized bicycle license is a restricted, noncommercial Class C license.

b. The license is valid for operating a motorized bicycle.

c. The license is issued for two years.

602.24(2) Requirements.

a. An applicant shall be at least 14 years of age.

b. An applicant under 16 years of age must submit proof of successful completion of an Iowa-approved course in motorized bicycle education.

This rule is intended to implement Iowa Code sections 321.177 and 321.189.

761—602.25(321) Minor's restricted license.**602.25(1) Validity and issuance.**

a. A minor's restricted license is a restricted, noncommercial Class C or Class M driver's license.

b. The license is valid for driving to and from the licensee's place of employment or to transport dependents to and from temporary care facilities, if necessary to maintain the licensee's present employment.

c. The type of motor vehicle that may be operated is controlled by the class of driver's license issued. A Class C minor's restricted license is valid for operating a motorcycle only if the license has a motorcycle endorsement. A minor's restricted license is valid for operating a motorized bicycle only for the purposes specified in paragraph "b" of this subrule.

d. The license is issued for two years.

602.25(2) Requirements.

a. The applicant shall be at least 16 years of age but not yet 18.

b. The applicant shall submit to the department a statement from the employer confirming the applicant's employment.

c. Proof of nonattendance is required. Proof of nonattendance is receipt of notification from the appropriate school authority that the applicant does not attend school, as set out in 761—subrule 615.23(2).

d. The applicant shall submit proof of successful completion of an Iowa-approved course in driver education.

e. For a Class M minor's restricted license or a motorcycle endorsement, the applicant shall also submit proof of successful completion of an Iowa-approved course in motorcycle rider education.

This rule is intended to implement Iowa Code sections 299.1B, 321.178, 321.180B, 321.189, 321.196 and 321.213B.

761—602.26(321) Minor's school license.**602.26(1) Validity and issuance.**

- a. A minor's school license is a restricted, noncommercial Class C or Class M driver's license.
- b. The license is valid during the times and for the purposes set forth in Iowa Code section 321.194 and at any time when the licensee is accompanied in accordance with Iowa Code section 321.180B(1).
- c. The type of motor vehicle that may be operated is controlled by the class of driver's license issued. A Class C minor's school license is valid for operating a motorcycle only if the license has a motorcycle endorsement. A minor's school license is valid for operating a motorized bicycle.
- d. The license is issued for two years.

602.26(2) Requirements.

- a. An applicant shall be at least 14 years of age but not yet 18 and meet the requirements of Iowa Code section 321.194.
- b. An applicant who attends a public school shall submit a statement of necessity signed by the chairperson of the school board, the superintendent of the school, or the principal of the school if authorized by the superintendent. An applicant who attends an accredited nonpublic school shall submit a statement of necessity signed by an authority in charge of the accredited nonpublic school or a duly authorized representative of the authority. The statement shall be on Form 430021.
- c. An applicant shall submit proof of successful completion of an Iowa-approved course in driver education.
- d. For a Class M minor's school license or a motorcycle endorsement, an applicant shall also submit proof of successful completion of an Iowa-approved course in motorcycle rider education.

602.26(3) Exemption.

a. An applicant is not required to have completed an approved driver education course if the applicant demonstrates to the satisfaction of the department that completion of the course would impose a hardship upon the applicant; however, the applicant must meet all other requirements for a school license. "Hardship" means:

- (1) If the applicant is 14 years old, that a driver education course will not begin at the applicant's school(s) of enrollment or at a public school in the applicant's district of residence within one year following the applicant's fourteenth birthday; or
- (2) If the applicant is 15 years old, that a driver education course will not begin at the applicant's school(s) of enrollment or at a public school in the applicant's district of residence within six months following the applicant's fifteenth birthday; or
- (3) If the applicant is between 16 and 18 years old, that a driver education course is not offered at the applicant's school(s) of enrollment or at a public school in the applicant's district of residence at the time the request for hardship status is submitted to the department; or
- (4) That the applicant is a person with a disability. In this rule, "person with a disability" means that, because of a disability or impairment, the applicant is unable to walk in excess of 200 feet unassisted or cannot walk without causing serious detriment or injury to the applicant's health.

b. "Demonstrates to the satisfaction of the department" means that the department has received written proof that a hardship exists. An applicant who attends a public school shall submit written proof of hardship signed by the applicant's parent, custodian or guardian and by the superintendent, the chairperson of the school board, or the principal, if authorized by the superintendent, of the applicant's school or school district of residence. An applicant who attends an accredited nonpublic school shall submit written proof of hardship signed by the applicant's parent, custodian or guardian and by either an authority in charge of the accredited nonpublic school or a duly authorized representative of the authority, or by the superintendent, the chairperson of the school board, or the principal, if authorized by the superintendent, of the applicant's school district of residence.

602.26(4) Multiple residences.

a. An applicant whose parents are divorced or separated and who as a result of shared custody maintains more than one residence may be authorized to operate a motor vehicle from either residence during the times and for the purposes set forth in Iowa Code section 321.194 if one of the following applies:

(1) If the applicant attends a public school, the statement of necessity provided to the department certifies that a need exists to drive from each residence, that the school of enrollment identified in the statement of necessity meets the geographic requirements for an applicant attending a public school set forth in Iowa Code section 321.194 as determined by the primary residence identified in the statement of necessity, and that the secondary residence identified in the statement of necessity is either within the school district that includes the applicant's school of enrollment or within an Iowa school district contiguous to the applicant's school of enrollment.

(2) If the applicant attends an accredited nonpublic school, the statement of necessity provided to the department certifies that a need exists to drive from each residence, that the school of enrollment identified in the statement of necessity meets the geographic requirements for an applicant attending an accredited nonpublic school set forth in Iowa Code section 321.194 as determined by the primary residence identified in the statement of necessity, and that the secondary residence identified in the statement of necessity is no more than 50 miles driving distance from the school of enrollment.

b. The fact that either residence is less than one mile from the applicant's school of enrollment shall not preclude travel to and from each residence at the times and for the purposes set forth in Iowa Code section 321.194 provided that need is otherwise demonstrated.

c. A minor's school license approved for travel to and from two residences for the purposes set forth in Iowa Code section 321.194 shall not be valid for travel directly between each residence unless the licensee is accompanied in accordance with Iowa Code section 321.180B(1).

d. The primary residential address listed in the statement of necessity shall appear on the face of the license. A minor's school license approved for travel to and from two residences shall include a "J" restriction on the face of the license, and the secondary address listed in the statement of necessity shall be listed on the reverse side of the license as part of the "J" restriction, with the following notation: "Also valid to drive to and from [secondary residential address] in compliance with 321.194."

This rule is intended to implement Iowa Code sections 321.177, 321.180B, 321.189, 321.194 and 321.196.

[ARC 2644C, IAB 8/3/16, effective 9/7/16; ARC 4271C, IAB 1/30/19, effective 3/6/19; ARC 4759C, IAB 11/6/19, effective 12/11/19; ARC 5258C, IAB 11/4/20, effective 12/9/20]

761—602.27 to 602.29 Reserved.

761—602.30(321) Special instruction permit. Rescinded IAB 1/8/92, effective 2/12/92.

[Filed 1/20/88, Notice 12/2/87—published 2/10/88, effective 3/16/88]¹

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[Filed ARC 2985C (Notice ARC 2908C, IAB 1/18/17), IAB 3/15/17, effective 4/19/17]

[Filed ARC 4271C (Notice ARC 4161C, IAB 12/5/18), IAB 1/30/19, effective 3/6/19]

[Filed ARC 4586C (Notice ARC 4476C, IAB 6/5/19), IAB 7/31/19, effective 9/4/19]

[Filed ARC 4759C (Notice ARC 4624C, IAB 8/28/19), IAB 11/6/19, effective 12/11/19]
[Filed ARC 4851C (Notice ARC 4715C, IAB 10/23/19), IAB 1/1/20, effective 2/5/20]
[Filed ARC 5204C (Notice ARC 5102C, IAB 7/29/20), IAB 10/7/20, effective 11/11/20]
[Filed ARC 5258C (Notice ARC 5154C, IAB 8/26/20), IAB 11/4/20, effective 12/9/20]
[Filed ARC 5495C (Notice ARC 5384C, IAB 1/13/21), IAB 3/10/21, effective 4/14/21]

¹ Effective date delayed 70 days by the Administrative Rules Review Committee at its March 9, 1988, meeting. Delay lifted by ARRC, April 21, 1988.

CHAPTER 604
LICENSE EXAMINATION

[Prior to 6/3/87, see Transportation Department[820]—(07,C)rules 13.3 and 13.17]

761—604.1(321) Authority and scope.

604.1(1) The department is authorized to determine by examination an applicant's ability to operate motor vehicles safely upon the highways and to issue all driver's licenses.

604.1(2) This chapter of rules shall apply to the examination for all driver's licenses. Information on the additional examination procedures and requirements for a commercial driver's license or commercial learner's permit is given in 761—Chapter 607.

This rule is intended to implement Iowa Code sections 321.2, 321.3, 321.13, 321.177, and 321.186. [ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

761—604.2(321) Definitions.

"Binocular field of vision" is the sum of the temporal measurements or the sum of the nasal measurements.

"Monocular field of vision" is the sum of the temporal measurement and the nasal measurement for one eye.

"Representative vehicle" is a vehicle which is characteristic of and requires operating skills comparable to those vehicles that may legally be operated under the class of license or endorsement desired.

This rule is intended to implement Iowa Code sections 321.174 and 321.186. [ARC 9991B, IAB 2/8/12, effective 3/14/12]

761—604.3(17A) Information and forms.

604.3(1) Applications, forms, and information about driver's license examinations are available at any driver's license service center. Assistance is also available from the driver and identification services bureau by mail at Driver and Identification Services Bureau, Iowa Department of Transportation, P.O. Box 9204, Des Moines, Iowa 50306-9204; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (515)244-8725; by facsimile at (515)239-1837; or on the department's website at www.iowadot.gov.

604.3(2) The "Iowa Driver Manual" and the "Iowa Motorcycle Operator Manual" are also available from the department and on the department's website at www.iowadot.gov.

This rule is intended to implement Iowa Code section 17A.3. [ARC 5048C, IAB 6/3/20, effective 7/8/20]

761—604.4 to 604.6 Reserved.

761—604.7(321) Examination.

604.7(1) An examination shall include:

- a. A vision screening if the person has not filed a vision report.
- b. A knowledge test of Iowa traffic laws and highway signs.
- c. A driving test of the person's ability to operate a motor vehicle.

604.7(2) The examination required for a driver's license depends upon the class of license requested, applicable endorsements, and the qualifications of the applicant.

This rule is intended to implement Iowa Code sections 321.186 and 321.186A.

761—604.8 and 604.9 Reserved.

761—604.10(321) Vision screening.

604.10(1) Requirement. Vision screening or a vision report is required of an applicant for a driver's license.

604.10(2) Method. At driver's license service centers, a vision screening instrument shall be used to screen the applicant's vision. An applicant who has corrective lenses may be screened with or without the corrective lenses.

604.10(3) Report. A vision report shall be submitted on Form 430032 signed by a licensed vision specialist and shall report the person's visual acuity level and field of vision as measured within 30 days prior to the date of the application. In lieu of Form 430032, a vision report signed by a licensed vision specialist on the specialist's letterhead may be accepted if it contains all the information specified on Form 430032.

604.10(4) Exception for persons renewing electronically. An applicant renewing a driver's license electronically pursuant to 761—subrule 605.25(7) is not required to complete a vision screen or submit a vision report to complete the renewal. This subrule does not preclude the department from requiring a vision screen or vision report of a person who has renewed a driver's license electronically when the department has reason to believe that the person is not capable of operating a motor vehicle safely.

This rule is intended to implement Iowa Code sections 321.186, 321.186A and 321.196.
[ARC 9991B, IAB 2/8/12, effective 3/14/12; ARC 0895C, IAB 8/7/13, effective 7/9/13; ARC 1073C, IAB 10/2/13, effective 11/6/13; ARC 5048C, IAB 6/3/20, effective 7/8/20]

761—604.11(321) Vision standards. The visual acuity and field of vision standards for licensing and the applicable restrictions are as follows.

604.11(1) Visual acuity standards.

a. When the applicant is screened without corrective lenses. If the visual acuity is 20/40 or better with both eyes or with the better eye, no restriction will be imposed. If the visual acuity is less than 20/40 but at least 20/70 with both eyes or with the better eye, the applicant shall be restricted from driving when headlights are required.

b. When the applicant is screened with corrective lenses. If the visual acuity is 20/40 or better with both eyes or with the better eye, the applicant shall be required to wear corrective lenses. If the visual acuity is less than 20/40 but at least 20/70 with both eyes or with the better eye, the applicant shall be required to wear corrective lenses and shall be restricted from driving when headlights are required.

c. Other standards. If the visual acuity in the left eye is less than 20/100, the applicant shall be restricted to driving a vehicle with both left and right outside rearview mirrors. However, if the applicant has a visual acuity of 20/40 in the right eye and less than 20/100 in the left eye without corrective lenses and has corrective lenses that improve the vision in the left eye to better than 20/100, the applicant shall have the option of being restricted to driving with corrective lenses or driving a vehicle with both left and right outside rearview mirrors.

604.11(2) Field of vision standards.

a. If the binocular field of vision is at least 140 degrees, no restriction will be imposed.

b. If the binocular field of vision is less than 140 degrees but at least 110 degrees, or one eye has a monocular field of vision of at least 100 degrees, the applicant shall be restricted to driving a vehicle with both left and right outside rearview mirrors.

This rule is intended to implement Iowa Code sections 321.186, 321.193, and 321.196.
[ARC 9991B, IAB 2/8/12, effective 3/14/12]

761—604.12(321) Vision referrals.

604.12(1) Referral.

a. If during any vision screening, an applicant cannot attain 20/40 with at least one eye but can attain 20/70 with at least one eye, the department shall not issue a license to the applicant. Instead, the department shall advise the applicant to consult a licensed vision specialist.

b. A vision report, pursuant to subrule 604.10(3), shall be required before the department will reconsider licensing.

604.12(2) License. If the applicant's license is valid, the department may issue a temporary driving permit with restrictions appropriate to the applicant's visual acuity level and field of vision. If the applicant's license is valid for less than 30 days, the temporary driving permit shall not be valid for more than 60 days from the end of the current license validity.

604.12(3) Report. If the vision report recommends a restriction, the department shall issue a restricted license even though it would not be required by departmental standards.

604.12(4) Applicant refusal. If an applicant refuses to consult a licensed vision specialist, the department shall issue or deny the license based on the results achieved on the vision screening.

This rule is intended to implement Iowa Code sections 321.181, 321.186, 321.186A, 321.193 and 321.196.

[ARC 5048C, IAB 6/3/20, effective 7/8/20]

761—604.13(321) Vision screening results.

604.13(1) Two-year license. An applicant who cannot attain a visual acuity of 20/40 with both eyes or with the better eye shall be issued a two-year license.

604.13(2) License denied.

a. An applicant who cannot attain a visual acuity of 20/70 with both eyes or with the better eye shall not be licensed, subject to discretionary issuance under subrule 604.13(4).

b. If the applicant's binocular field of vision is less than 110 degrees, or the monocular field of vision is less than 100 degrees, the applicant shall not be licensed, subject to discretionary issuance under subrule 604.13(4).

604.13(3) Reapplication. An applicant who cannot meet the vision standards in subrule 604.13(2) may reapply when the vision improves and the applicant meets the vision standards. If a suspension or denial notice was served, reapplication must be made to the driver and identification services bureau at the address in subrule 604.3(1), or at a driver's license service center.

604.13(4) Discretionary issuance.

a. An applicant whose license is restricted under rule 761—604.11(321) or who cannot meet the vision standards in subrule 604.13(2) may submit a written request for review by an informal settlement officer.

b. Based upon consideration of the applicant's vision report, driving test and driving record, the written recommendation of the applicant's licensed vision specialist, and traffic conditions in the vicinity of the applicant's residence, the officer may recommend issuing a license with restrictions suitable to the applicant's capabilities. However:

(1) An applicant who cannot attain a visual acuity of 20/100 with both eyes or with the better eye may be considered for licensing only after recommendation by the medical advisory board.

(2) An applicant who cannot attain a visual acuity of 20/199 with both eyes or with the better eye shall not be licensed.

(3) If an applicant's binocular field of vision or monocular field of vision is less than 75 degrees, the applicant may be considered for licensing only after recommendation by the medical advisory board.

(4) An applicant who cannot attain a binocular or monocular field of vision of 21 degrees shall not be licensed.

c. The officer's recommendation denying discretionary issuance or regarding the extent and nature of restrictions is subject to reversal or modification upon review or appeal only if it is clearly characterized by an abuse of discretion.

This rule is intended to implement Iowa Code sections 321.186, 321.186A, 321.193 and 321.196.

[ARC 9991B, IAB 2/8/12, effective 3/14/12; ARC 5048C, IAB 6/3/20, effective 7/8/20]

761—604.14 to 604.19 Reserved.

761—604.20(321) Knowledge test.

604.20(1) Written test. A knowledge test is a written test to determine an applicant's ability to read and understand Iowa traffic laws and the highway signs that regulate, warn, and direct traffic. A test may be revised at any time but each test states the minimum passing score.

604.20(2) Three types of tests. There are three types of knowledge tests: an operator's test, a chauffeur's test, and a motorcycle test. The requirement for a license depends upon the class of license desired, applicable endorsements, and the qualifications of the applicant.

604.20(3) Oral test. An applicant who is unable to read or understand a written test may request an oral test. The oral test may be administered by an examiner or by an automated testing device.

604.20(4) Retesting. An applicant who fails a knowledge test may repeat the test at the discretion of the examiner, but at least one business day shall elapse between tests.

This rule is intended to implement Iowa Code section 321.186.
[ARC 5048C, IAB 6/3/20, effective 7/8/20]

761—604.21(321) Knowledge test requirements and waivers.

604.21(1) Knowledge test requirements. The knowledge test requirements are as follows:

a. Operator's test. An operator's knowledge test is required for all classes of driver's licenses and all types of special driver's licenses and permits.

b. Motorcycle test. A motorcycle knowledge test is required for all:

- (1) Motorcycle instruction permits.
- (2) Class M driver's licenses.
- (3) Motorcycle endorsements.

c. Chauffeur's test. A chauffeur's knowledge test is required for all:

- (1) Chauffeur's instruction permits.
- (2) Class D driver's licenses except those with an endorsement for "passenger vehicle less than 16-passenger design."

604.21(2) Knowledge test waivers. The department may waive a knowledge test listed in subrule 604.21(1) if the applicant meets one of the following qualifications:

a. The applicant has passed the same type of test for another Iowa driver's license or an equivalent out-of-state license that is still valid or has expired within the past year.

b. The applicant has a valid, equivalent driver's license issued by a foreign jurisdiction with which Iowa has a nonbinding reciprocity agreement.

c. The applicant has a military extension and is renewing the applicant's Iowa driver's license within six months following separation from active duty.

d. The applicant is renewing an Iowa driver's license or endorsement within a period of one year after the expiration date of the license or endorsement.

e. The applicant is reinstating from a denial, cancellation, suspension, revocation, disqualification or bar of an Iowa driver's license or endorsement within a period of one year after the expiration date of the denial, cancellation, suspension, revocation, disqualification or bar.

This rule is intended to implement Iowa Code sections 321.180, 321.180A, 321.180B, 321.186, 321.189, 321.196 and 321.198.

[ARC 5048C, IAB 6/3/20, effective 7/8/20]

761—604.22(321) Knowledge test results. Rescinded ARC 5048C, IAB 6/3/20, effective 7/8/20.

761—604.23 to 604.29 Reserved.

761—604.30(321) Driving test. A driving test is a demonstration of an applicant's ability to exercise ordinary and reasonable control in the operation of a motor vehicle under actual traffic conditions. The test is also called a road test, field test, or driving demonstration. A motorcycle skill test is an off-street demonstration of an applicant's ability to control the motorcycle in a set of standard maneuvers, and a motorcycle driving test is an on-street demonstration.

604.30(1) Vehicle type and safety.

a. For the driving test, the applicant shall provide a representative vehicle as defined in 761—604.2(321) and proof of financial responsibility for the representative vehicle.

b. The examiner or other authorized personnel shall visually inspect the vehicle. If a vehicle is illegal or unsafe, or is not a representative vehicle, the examiner shall refuse to administer the test until corrections are made or an acceptable vehicle is provided.

604.30(2) Criteria and route. Form 430024, "Your Driving Test," explains the criteria for passing the test and shall be given to the applicant before any required test, except a motorcycle skill test. The

applicant shall be directed over one of the routes which have been preselected by the examiner to test driving skills and maneuvers.

604.30(3) Test score. The examiner shall use the standard departmental score sheet and shall enter the test score and the licensing decision in the spaces provided. At the end of the test, the examiner shall explain the test score. The test score result is valid for 90 days.

604.30(4) Retesting. If an applicant fails a driving test, the test may be rescheduled at the discretion of the examiner.

This rule is intended to implement Iowa Code sections 321.174 and 321.186.
[ARC 9991B, IAB 2/8/12, effective 3/14/12; ARC 5048C, IAB 6/3/20, effective 7/8/20]

761—604.31(321) Driving test requirements and waivers for noncommercial driver's licenses.

604.31(1) Driving test requirements. The driving test requirements for noncommercial driver's licenses are as follows:

- a. *Instruction permits.* A driving test is not required to obtain an instruction permit.
- b. *Class C driver's licenses.* For a Class C driver's license other than an instruction permit or a motorized bicycle license, an operator's driving test in a representative vehicle is required, except that an autocycle as defined in Iowa Code section 321.1 shall not be used for the driving test.
- c. *Class D driver's licenses.* For a Class D driver's license, a driving test in a representative vehicle for the endorsement requested, as set out in 761—subrule 605.7(3), is required.
- d. *Class M driver's licenses and motorcycle endorsements.* The driving test for a Class M driver's license or motorcycle endorsement consists of two parts: an off-street motorcycle skill test and an on-street driving test.

(1) The off-street motorcycle skill test is required. The on-street motorcycle driving test is also required if the applicant does not have another driver's license that permits unaccompanied driving. Neither motorcycle test is required for the purposes of operating an autocycle.

(2) A motorcycle shall be used for these tests. If a three-wheeled motorcycle is used, the driver's license shall be restricted: "Not valid for 2-wheel vehicle." An autocycle is not considered a motorcycle or a three-wheeled motorcycle for testing purposes.

e. *Motorized bicycle licenses.* For a motorized bicycle license, an off-street or on-street driving test may be required. A motorized bicycle shall be used for the test.

604.31(2) Driving test waivers. The department may waive a required driving test listed in subrule 604.31(1) if the applicant meets one of the following qualifications:

a. The applicant has successfully completed the appropriate Iowa-approved course or courses. The appropriate Iowa-approved courses are the following: driver education, other than driver education by a teaching parent under rule 761—634.11(321), for an applicant's first Class C driver's license that permits unaccompanied driving other than motorized bicycle; motorcycle rider education for a Class M driver's license or motorcycle endorsement; and motorized bicycle education for a motorized bicycle license. However, if an applicant is under the age of 18, a driving test is required if so requested by the applicant's parent, guardian, or instructor.

b. The applicant is renewing a Class C, Class D or Class M Iowa driver's license or endorsement within a period of one year after the expiration date of the license or endorsement.

c. The applicant is reinstating from a denial, cancellation, suspension, revocation, disqualification or bar of an Iowa driver's license or endorsement within a period of one year after the expiration date of the denial, cancellation, suspension, revocation, disqualification or bar.

d. The applicant has passed the same type of driving test for another Iowa driver's license or endorsement that is still valid or has expired within the past year.

e. The applicant has a military extension and is renewing the applicant's Iowa driver's license within six months following separation from active duty.

f. The applicant is applying for a Class C Iowa driver's license that permits unaccompanied driving and has an equivalent out-of-state license that is valid or has expired within the past year.

g. The applicant is applying for a Class D Iowa driver's license and has an equivalent out-of-state license that is valid or has expired within the past year.

h. The applicant is applying for a Class M driver's license or a motorcycle endorsement and has an equivalent out-of-state Class M driver's license or motorcycle endorsement that is valid or has expired within the past year.

i. The applicant has a valid, equivalent driver's license issued by a foreign jurisdiction with which Iowa has a nonbinding reciprocity agreement.

This rule is intended to implement Iowa Code sections 321.1, 321.174, 321.178, 321.178A, 321.180, 321.180A, 321.180B, 321.186, 321.189, 321.193, 321.196 and 321.198.

[ARC 7902B, IAB 7/1/09, effective 8/5/09; ARC 1612C, IAB 9/3/14, effective 10/8/14; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2985C, IAB 3/15/17, effective 4/19/17; ARC 4586C, IAB 7/31/19, effective 9/4/19; ARC 5048C, IAB 6/3/20, effective 7/8/20]

761—604.32(321) Driving tests requirements. Rescinded IAB 1/8/92, effective 2/12/92.

761—604.33 and 604.34 Reserved.

761—604.35(321) Determination of gross vehicle weight rating. For a vehicle that has no legible manufacturer's certification label, the applicant may provide documentation of the gross vehicle weight rating, such as a manufacturer's certificate of origin, a title, a vehicle registration document, or the vehicle identification number information for the vehicle. In the absence of the above documentation, the registered weight of the vehicle shall be presumed to be the gross vehicle weight rating.

This rule is intended to implement Iowa Code section 321.1.

761—604.36 to 604.39 Reserved.

761—604.40(321) Failure to pass examination.

604.40(1) An applicant who fails to pass a required examination or reexamination shall not be licensed.

a. If the applicant does not have a valid Iowa license, the department shall deny the applicant a license.

b. If the applicant has a valid Iowa license, the department shall suspend the license for incapability. However, if the applicant's license is valid for less than 30 days, the department shall deny further licensing. The department shall serve a notice of suspension or denial.

c. See 761—615.4(321) for further information on denials and 761—615.14(321) for further information on suspensions for incapability.

d. An applicant may contest a denial or suspension in accordance with 761—615.38(321).

604.40(2) Limitations on the hearing and appeal process.

a. After a suspension or denial for failure to pass a required knowledge or driving test, a person who contests the suspension or denial shall be deemed to have exhausted the person's administrative remedies after three unsuccessful attempts to pass the required test.

b. After the three unsuccessful attempts, no further testing shall be allowed until six months have elapsed from the date of the last test failure, and then only if the applicant demonstrates a significant change or improvement in those physical or mental factors that resulted in the original decision. A request for further testing must be submitted in writing to the driver and identification services bureau at the address in subrule 604.3(1).

c. Notwithstanding paragraphs "a" and "b" of this subrule, no testing shall occur if the director determines that it is unsafe to allow testing.

This rule is intended to implement Iowa Code chapter 17A and sections 321.177, 321.180A and 321.210.

[ARC 5048C, IAB 6/3/20, effective 7/8/20]

761—604.41 to 604.44 Reserved.

761—604.45(321) Reinstatement. A person whose license has been suspended or denied for failure to pass a required examination or reexamination shall meet the vision standards for licensing, pass the

required knowledge examination(s), and pass the required driving test(s) before an Iowa license will be issued.

This rule is intended to implement Iowa Code sections 321.177 and 321.186.

761—604.46 to 604.49 Reserved.

761—604.50(321) Special reexaminations.

604.50(1) As provided in Iowa Code section 321.186, the department may require a special reexamination of any licensee. The reexamination may consist of one or more of the following:

- a. Medical report.
- b. Vision report.
- c. Vision screening.
- d. Cognitive screening.
- e. Knowledge test.
- f. Driving test.

604.50(2) The department may require a special reexamination when a licensee has been involved in a fatal motor vehicle accident and the investigating officer's report of the accident indicates the licensee contributed to the accident.

604.50(3) The department may require a special reexamination when a licensee has been involved in two accidents within a three-year period and the investigating officer's report of each accident lists one of the following "Driver/Vehicle Related Contributing Circumstances" for the licensee:

- a. Ran traffic signal.
- b. Ran stop sign.
- c. Passing, interfered with other vehicle.
- d. Left of center, not passing.
- e. Failure to yield right-of-way at uncontrolled intersection.
- f. Failure to yield right-of-way from stop sign.
- g. Failure to yield right-of-way from yield sign.
- h. Failure to yield right-of-way making left turn.
- i. Failure to yield right-of-way to pedestrian.
- j. Failure to have control.

604.50(4) The department may require a special reexamination when a licensee has been involved in an accident and the investigating officer's report lists a driver condition for the licensee of "fatigue or asleep."

604.50(5) The department may require a special reexamination when a licensee who is 65 years of age or older has been involved in an accident and information in the investigating officer's or the person's own report of the accident indicates the need for reexamination. A circumstance that may indicate a need for reexamination includes, but is not limited to, any one of the following:

- a. The licensee made a left turn that resulted in the accident.
- b. The licensee failed to yield the right-of-way at a stop sign.
- c. The licensee failed to yield the right-of-way at a yield sign.
- d. The licensee failed to yield the right-of-way at an uncontrolled intersection.
- e. The licensee failed to yield the right-of-way at a traffic control signal.
- f. The licensee's vision may be a contributing factor to an accident.
- g. The licensee has a physical disability-related license restriction other than "corrective lenses" and the accident involved one of the circumstances listed in paragraphs "a" to "f" above.
- h. The investigating officer's report lists a driver condition for the licensee of "loss of consciousness."
- i. The investigating officer's report lists a driver condition for the licensee of "illness which resulted in the accident."

604.50(6) The department may require a special reexamination when the department receives an accident report or a recommendation by a peace officer, a court, or a properly documented citizen's

request. A factor that may indicate a need for reexamination includes, but is not limited to, any one of the following:

- a. Loss of consciousness.
- b. Confusion, disorientation or dementia.
- c. Inability to maintain a vehicle in the proper lane.
- d. Repeatedly ignoring traffic control devices in a nonchase setting.
- e. Inability to interact safely with other vehicles.
- f. Inability to maintain consistent speed when no reaction to other vehicles or pedestrians is required.
- g. Illness which resulted in an accident.

This rule is intended to implement Iowa Code sections 321.177, 321.186 and 321.210.
 [ARC 5048C, IAB 6/3/20, effective 7/8/20; ARC 5495C, IAB 3/10/21, effective 4/14/21]

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[Filed ARC 5495C (Notice ARC 5384C, IAB 1/13/21), IAB 3/10/21, effective 4/14/21]

¹ Effective date of 604.11(2) and 604.13(2)“b” delayed until adjournment of the 1988 Session of the General Assembly pursuant to Iowa Code section 17A.8(9) by the Administrative Rules Review Committee at its June 1987 meeting.

CHAPTER 605
LICENSE ISSUANCE

761—605.1(321) Scope. This chapter of rules applies to the issuance of all Iowa driver's licenses. Additional information on the issuance of a commercial driver's license or a commercial learner's permit is given in 761—Chapter 607.

This rule is intended to implement Iowa Code section 321.174.
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

761—605.2(321) Definitions. The definitions in Iowa Code section 321.1 and the following definitions apply to this chapter.

“License” means “driver's license” as defined in Iowa Code section 321.1(20A) unless the context otherwise requires.

“Medical report” means a report from a qualified medical professional attesting to a person's physical or mental capability to operate a motor vehicle safely. The report should be submitted on Form 430031, “Medical Report.” In lieu of Form 430031, a report signed by a qualified medical professional on the qualified medical professional's letterhead may be accepted if it contains all the information specified on Form 430031.

“Qualified medical professional” means a person licensed as a physician under Iowa Code chapter 148, a person licensed as an advanced registered nurse practitioner under Iowa Code chapter 152 and licensed with the board of nursing, or a person licensed as a physician assistant under Iowa Code chapter 148C, when practicing within the scope of the person's professional licensure.

This rule is intended to implement Iowa Code section 321.1.
[ARC 4586C, IAB 7/31/19, effective 9/4/19]

761—605.3(321) Persons exempt.

605.3(1) Persons listed in Iowa Code section 321.176 are exempt from driver's licensing requirements.

605.3(2) “Nearby” in Iowa Code section 321.176(2) shall mean a distance of not more than two miles.

This rule is intended to implement Iowa Code section 321.176.
[ARC 4586C, IAB 7/31/19, effective 9/4/19]

761—605.4(252J,321) Persons not to be licensed.

605.4(1) The department shall not knowingly issue a license to any person who is ineligible for licensing.

605.4(2) The department shall not knowingly license any person who is unable to operate a motor vehicle safely because of physical or mental disability until that person has submitted a medical report stating that the person is physically and mentally capable of operating a vehicle safely.

605.4(3) The department shall not knowingly license any person who has been specifically adjudged incompetent, pursuant to Iowa Code chapter 229, on or after January 1, 1976, including anyone admitted to a mental health facility prior to that date and not released until after, until the department receives specific adjudication that the person is competent. A medical report stating that the person is physically qualified to operate a motor vehicle safely shall also be required.

605.4(4) The department shall not knowingly license any person who suffers from syncope of any cause, any type of periodic or episodic loss of consciousness, or any paroxysmal disturbances of consciousness, including but not limited to epilepsy, until that person has not had an episode of loss of consciousness or loss of voluntary control for six months, and then only upon receipt of a medical report favorable toward licensing.

a. If a medical report indicates a pattern of only syncope, the department may license without a six-month episode-free period after favorable recommendation by the medical advisory board.

b. If a medical report indicates a pattern of such episodes only when the person is asleep or is sequestered for sleep, the department may license without a six-month episode-free period.

c. If an episode occurs when medications are withdrawn by a qualified medical professional, but the person is episode-free when placed back on medications, the department may license without a six-month episode-free period with a favorable recommendation from a neurologist.

d. If a medical report indicates the person experienced a single nonrecurring episode, the cause has been identified, and the qualified medical professional is not treating the person for the episode and believes it is unlikely to recur, the department may license without the six-month episode-free period with a favorable recommendation from a qualified medical professional.

605.4(5) The department shall not license any person who must wear bioptic telescopic lenses to meet the visual acuity standard required for a license.

605.4(6) When a medical report is required, a license shall be issued only if the report indicates that the person is qualified to operate a motor vehicle safely. The department may submit the report to the medical advisory board for an additional opinion.

605.4(7) When the department receives evidence that an Iowa licensed driver has been adjudged incompetent or is not physically or mentally qualified to operate a motor vehicle safely, the department shall suspend the license for incapability, as explained in rule 761—615.14(321), or shall deny further licensing, as explained in rule 761—615.4(321).

605.4(8) The department shall not knowingly issue a license to a person who is the named individual on a certificate of noncompliance that has been received from the child support recovery unit, until the department receives a withdrawal of the certificate of noncompliance or unless an application has been filed pursuant to Iowa Code section 252J.9.

This rule is intended to implement Iowa Code sections 252J.8, 252J.9, 321.13, 321.177, 321.210, and 321.212.

[ARC 4586C, IAB 7/31/19, effective 9/4/19]

761—605.5(321) Contents of license. In addition to the information specified in Iowa Code section 321.189(2), the following information shall be shown on a driver's license.

605.5(1) Name. The licensee's full legal name shall be listed as established according to 761—subrule 601.5(1) and 761—subrule 601.5(5) and shall conform to the requirements of 761—subrule 601.1(2).

605.5(2) Current residential address. The licensee's current residential address shall be listed as established according to the requirements of 761—subrule 601.5(3).

605.5(3) Physical description. The physical description of the licensee on the face of the driver's license shall include:

a. The licensee's eye color using these abbreviations: Blk-black, Blu-blue, Bro-brown, Dic-dichromatic, Gry-gray, Grn-green, Haz-hazel, Pnk-pink and Unk-unknown.

b. The licensee's height in inches.

605.5(4) Date of birth. The licensee's date of birth shall be listed as established according to 761—subrule 601.5(1) and 761—subrule 601.5(6).

605.5(5) Sex. The licensee's sex designation shall be listed as established according to the requirements of 761—subrule 601.5(7).

605.5(6) REAL ID markings.

a. A driver's license that is issued as a REAL ID license as defined in 761—601.7(321) shall include a security marking as required by 6 CFR 37.17(n).

b. A driver's license that is not issued as a REAL ID license as defined in 761—601.7(321) may be marked as required by 6 CFR 37.71 and any subsequent guidance issued by the U.S. Department of Homeland Security.

c. A driver's license issued to a foreign national with temporary lawful status shall include the following statement on the face of the license: "limited term."

605.5(7) Voluntary markings. Upon the request of the licensee, the department shall indicate on the driver's license any of the following:

a. The presence of a medical condition.

b. That the licensee is a donor under the uniform anatomical gift law.

- c. That the licensee has in effect a medical advance directive.
- d. That the licensee is hard of hearing or deaf.
- e. That the licensee is a veteran.

(1) To be eligible for a veteran designation, the licensee must be an honorably discharged veteran of the armed forces of the United States, the national guard or reserve forces. A licensee who requests a veteran designation shall submit Form 432035, properly completed by the licensee and a designee of the Iowa department of veterans affairs, or the licensee shall present certification of release or discharge from active duty, DD form 214, to the department indicating that the licensee was honorably discharged from active duty. A licensee who was a member of the national guard or reserve forces and who applies directly to the department must present a DD form 214 which indicates that the licensee was honorably discharged after serving for at least a minimum aggregate (total) of 90 days of active duty service for purposes other than training. A licensee who was a member of the national guard or reserve forces and who has a discharge document other than a DD form 214 must have the licensee's eligibility for a veteran designation determined by a designee of the Iowa department of veterans affairs and shall apply to the department for a veteran designation by submitting Form 432035, properly completed by the licensee and a designee of the Iowa department of veterans affairs.

(2) The department may consult with and defer to the Iowa department of veterans affairs regarding what constitutes a properly completed DD form 214 and veteran status in general.

(3) If the department denies issuance of a license with a veteran designation upon presentation of the DD form 214 to the department, the licensee may obtain a license with a veteran designation if the licensee submits Form 432035, properly completed by the licensee and a designee of the Iowa department of veterans affairs.

(4) If the department issues a veteran designation in error or as the result of fraud on the part of the licensee, the driver's license with a veteran designation shall be canceled, and a duplicate license without the designation may be issued to the licensee. There shall be no charge to issue a duplicate license if the license was issued in error, unless the error was the result of fraud on the part of the licensee.

- f. That the licensee has autism spectrum disorder.

This rule is intended to implement Iowa Code sections 142C.3 and 321.189, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[ARC 0347C, IAB 10/3/12, effective 11/7/12; ARC 1714C, IAB 11/12/14, effective 12/17/14; ARC 2888C, IAB 1/4/17, effective 2/8/17; ARC 4000C, IAB 9/12/18, effective 10/17/18; ARC 4000C, IAB 9/12/18, effective 10/17/18; ARC 4586C, IAB 7/31/19, effective 9/4/19; ARC 5302C, IAB 12/2/20, effective 1/6/21]

761—605.6(321) License class. The driver's license class shall be coded on the face of the driver's license using these codes:

- Class A—commercial driver's license
- Class B—commercial driver's license
- Class C—commercial driver's license
- Class C—noncommercial driver's license
- Class D—noncommercial driver's license, chauffeur
- Class M—noncommercial driver's license, motorcycle only

This rule is intended to implement Iowa Code section 321.189.

[ARC 0347C, IAB 10/3/12, effective 11/7/12; ARC 4586C, IAB 7/31/19, effective 9/4/19]

761—605.7(321) Endorsements. The endorsements shall be coded on the face of the driver's license and explained in text on the back of the driver's license.

605.7(1) For a commercial driver's license. The following endorsements may be added to a Class A, B or C commercial driver's license using these letter codes:

- H—Hazardous material
- P—Passenger
- N—Tank
- X—Hazardous material and tank
- T—Double/triple trailers

S—School bus

605.7(2) *For a commercial learner's permit.* The following endorsements are the only endorsements that may be added to a commercial learner's permit using these letter codes. All other endorsements are prohibited on a commercial learner's permit.

P—Passenger

N—Tank

S—School bus

605.7(3) *For a Class D driver's license (chauffeur).* The following endorsements may be added to a Class D driver's license using these number codes:

1—Truck-tractor semitrailer combination

2—Vehicle with 16,001 pounds gross vehicle weight rating or more. Not valid for truck-tractor semitrailer combination

3—Passenger vehicle less than 16-passenger design

605.7(4) *Motorcycle endorsement.* A motorcycle endorsement may be added to any driver's license that permits unaccompanied driving, other than a Class M driver's license or a motorized bicycle license, using the following letter code:

L—Motorcycle

This rule is intended to implement Iowa Code sections 321.180 and 321.189.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 4000C, IAB 9/12/18, effective 10/17/18; ARC 4586C, IAB 7/31/19, effective 9/4/19]

761—605.8(321) Restrictions. Restrictions shall be coded on the face of the driver's license and explained in text on the back of the driver's license. For purposes of this rule, "CMV" means commercial motor vehicle.

605.8(1) *For all licenses.* The following restrictions may apply to any driver's license:

B—Corrective lenses required

C—Mechanical aid (as detailed in the restriction on the back of the card)

D—Prosthetic aid (as detailed in the restriction on the back of the card)

F—Left and right outside rearview mirrors

G—No driving when headlights required

H—Temporary restricted license or permit (work permit)

I—Ignition interlock required

J—Restrictions on the back of card

S—SR required (proof of financial responsibility for the future)

T—Medical report required at renewal

U—Not valid for 2-wheel vehicle

W—Restricted commercial driver's license (CDL)

Y—Intermediate license

605.8(2) *For a noncommercial driver's license.* The following restrictions apply only to a noncommercial driver's license:

8—Special instruction permit

9—Passenger restriction for intermediate license

Q—No interstate or freeway driving

605.8(3) *For a commercial driver's license.* The following restrictions apply to a commercial driver's license:

E—No manual transmission equipped CMV

K—Intrastate only

L—No air brake equipped CMV

M—No Class A passenger vehicle

N—No Class A and B passenger vehicle

O—No tractor trailer CMV

V—Medical variance

Z—No full air brake equipped CMV

605.8(4) *For a commercial learner's permit.* The following restrictions apply to a commercial learner's permit.

K—Intrastate only

L—No air brake equipped CMV

M—No Class A passenger vehicle

N—No Class A and B passenger vehicle

P—No passengers in CMV bus

V—Medical variance

X—No cargo in CMV tank vehicle

605.8(5) *Special licenses.* A numbered restriction will designate a special driver's license using these codes:

1—Motorcycle instruction permit

2—Noncommercial instruction permit (vehicle less than 16,001 gross vehicle weight rating)

3—Commercial learner's permit

4—Chauffeur's instruction permit

5—Motorized bicycle license

6—Minor's restricted license

7—Minor's school license

605.8(6) *Additional information.*

a. Reexamination or report. The department may issue a restriction requiring a person to reappear at a specified time for examination. The department may require a medical report to be submitted. The department shall send Form 430029 as a reminder to appear.

b. Loss of consciousness or voluntary control.

(1) If a person is licensed pursuant to subrule 605.4(4), the department shall issue the first driver's license with a restriction stating: "Medical report to be furnished at the end of six months."

(2) If this medical report shows that the person has been free of an episode of loss of consciousness or voluntary control since the previous medical report and the report recommends licensing, the department shall issue a duplicate driver's license with a restriction stating: "Medical report required at renewal." At each renewal accompanied by a favorable medical report, the department shall issue a two-year driver's license with the same restriction.

(3) If the latest medical report indicates the person experienced only a single nonrecurring episode, the cause has been identified, and the qualified medical professional is not treating or has not treated the person for the episode and believes it is unlikely to recur, the department may waive the medical report requirement upon receipt of a favorable recommendation from a qualified medical professional.

(4) The department may remove the medical report requirement and issue a full-term driver's license if recommended by a qualified medical professional and if the latest medical information on file with the department indicates the person has not had an episode of loss of consciousness or voluntary control and has not been prescribed medications to control such episodes during the 24-month period immediately preceding application for a license.

(5) The department may remove the medical report requirement and issue a full-term driver's license if recommended by a qualified medical professional and if the latest medical information on file with the department indicates the person has not had an episode of loss of consciousness or voluntary control during the 10-year period immediately preceding application for a license.

c. Financial responsibility. When a person is required under Iowa Code chapter 321A to have future proof of financial responsibility on file, the license restriction will read: "SR required." The license shall be valid only for the operation of motor vehicles covered by the class of license issued and by the proof of financial responsibility filed.

d. Vision restriction. Restrictions relating to vision are addressed in 761—Chapter 604.

This rule is intended to implement Iowa Code chapter 321A and sections 321.178, 321.180, 321.180A, 321.180B, 321.188, 321.189, 321.193, 321.194, 321.215, 321J.4, and 321J.20.

[ARC 9991B, IAB 2/8/12, effective 3/14/12; ARC 0661C, IAB 4/3/13, effective 5/8/13; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 4000C, IAB 9/12/18, effective 10/17/18; ARC 4586C, IAB 7/31/19, effective 9/4/19]

761—605.9(321) License term for temporary foreign national. A driver’s license issued to a person who is a foreign national with temporary lawful status shall be issued only for the length of time the person is authorized to be present as verified by the department, not to exceed two years. However, if the person’s lawful status as verified by the department has no expiration date, the driver’s license shall be issued for a period of no longer than one year.

This rule is intended to implement Iowa Code section 321.196, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[ARC 0347C, IAB 10/3/12, effective 11/7/12; ARC 4586C, IAB 7/31/19, effective 9/4/19]

761—605.10(321) Fees for driver’s licenses. Fees for driver’s licenses are specified in Iowa Code section 321.191. A license fee may be paid by cash, check, credit card, debit card or money order.

605.10(1) If the payment is by check, the check shall be for the exact amount of the fee and shall be payable to: Treasurer, State of Iowa. An exception may be made when a traveler’s check is presented.

605.10(2) One payment method may be used to pay fees for several persons, such as members of a family or employees of a business firm. One payment method may pay all fees involved, such as the license fee and the reinstatement fee.

This rule is intended to implement Iowa Code section 321.191.

[ARC 9991B, IAB 2/8/12, effective 3/14/12; ARC 4586C, IAB 7/31/19, effective 9/4/19; ARC 5302C, IAB 12/2/20, effective 1/6/21]

761—605.11(321) Duplicate license.

605.11(1) *Lost, stolen or destroyed license.* To replace a valid license that is lost, stolen or destroyed, the licensee shall provide the licensee’s full legal name, date of birth, and social security number, all of which must be verified by the department, and pay the replacement fee. A licensee subject to 761—paragraph 601.5(2)“b” shall provide the applicant’s U.S. Customs and Immigration Services number, which must be verified by the department. The department may investigate or require additional information as may be reasonably necessary to determine that the licensee’s identity matches the identity of record and shall not issue the replacement license if the licensee’s identity is questionable, cannot be determined, or otherwise does not match the identity of record. If the licensee’s current residential address, name, date of birth, or sex designation has changed since the previous license was issued, the licensee shall comply with subrule 605.11(2).

605.11(2) *Voluntary replacement.* The department shall issue a duplicate of a valid license to an eligible licensee if the license is surrendered to the department and the replacement fee is paid. Voluntary replacement includes but is not limited to:

- a. Replacement of a damaged license.
- b. Replacement to change the current residential address on a license. The licensee shall notify the department to establish the current residential address.
- c. Replacement to change the name on a license. The licensee shall comply with the requirements of 761—subrule 601.5(5) to establish a name change.
- d. Replacement to change the date of birth on a license. The licensee shall comply with the requirements of 761—subrule 601.5(6) to establish a change of date of birth.
- e. Replacement to change the sex designation on a license. The licensee shall comply with the requirements of 761—subrule 601.5(7) to establish a change of sex designation.
- f. Issuance of a license without the words “under 21” to a licensee who is 21 years of age or older.
- g. Issuance of a license without the words “under 18” to a licensee who is 18 years of age or older. (If the licensee is under 21 years of age, the words “under 21” will replace the words “under 18.”)
- h. Issuance of a noncommercial driver’s license to an eligible person who has been disqualified from operating a commercial motor vehicle.

i. Replacement of a valid license before its expiration date to obtain a license that may be accepted for federal identification purposes under 6 CFR Part 37 (a REAL ID license). The licensee shall comply with the requirements of 761—601.5(321) to obtain a REAL ID license.

j. Replacement to add a veteran designation to the license. To be eligible for a veteran designation, the licensee must comply with the requirements of paragraph 605.5(7)“e.”

605.11(3) Replacement upon attaining the age of 21. A licensee, upon attaining the age of 21, who is otherwise eligible for a driver’s license is eligible to electronically apply for a replacement driver’s license under this rule for the unexpired months of the license, regardless of whether the most recent issuance occurred electronically.

a. Except for the requirements in subparagraphs 605.25(7)“a”(1) and 605.25(7)“a”(2), the licensee must meet the eligibility requirements listed in paragraph 605.25(7)“a” to replace the license electronically and must also meet the following criteria:

(1) The licensee must be at least 21 years old.

(2) The licensee must currently hold a driver’s license marked “Under 21” as provided in Iowa Code section 321.189.

b. Notwithstanding any other provision of this chapter to the contrary, the department may accept an electronic replacement application if the licensee seeks replacement of a special instruction permit or a license with a single “J” restriction accompanied by a “9” restriction.

605.11(4) Fee. The fee to replace a license is \$10.

This rule is intended to implement Iowa Code sections 321.13, 321.189, 321.195 and 321.208, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[ARC 7902B, IAB 7/1/09, effective 8/5/09; ARC 0347C, IAB 10/3/12, effective 11/7/12; ARC 1714C, IAB 11/12/14, effective 12/17/14; ARC 2888C, IAB 1/4/17, effective 2/8/17; ARC 3451C, IAB 11/8/17, effective 12/13/17; ARC 4000C, IAB 9/12/18, effective 10/17/18; ARC 4586C, IAB 7/31/19, effective 9/4/19; ARC 4851C, IAB 1/1/20, effective 2/5/20]

761—605.12(321) Address changes.

605.12(1) A licensee shall notify the department of a change in the licensee’s mailing address within 30 days of the change. Notice shall be given by:

a. Submitting the address change in writing to the Driver and Identification Services Bureau, Iowa Department of Transportation, P.O. Box 9204, Des Moines, Iowa 50306-9204; or

b. Completing the address change on the department’s website at www.iowadot.gov or at a driver’s license kiosk; or

c. Appearing in person to change the mailing address at any driver’s license service center.

605.12(2) Parents or legal guardians may provide written notice of a mailing address change on behalf of their minor children.

605.12(3) The department may use U.S. Postal Service address information to update its address records.

This rule is intended to implement Iowa Code sections 321.182 and 321.184.

[ARC 4000C, IAB 9/12/18, effective 10/17/18; ARC 4851C, IAB 1/1/20, effective 2/5/20]

761—605.13 and 605.14 Reserved.

761—605.15(321) License extension.

605.15(1) Six-month extension. An Iowa resident may apply for a noncommercial six-month extension of a license if the resident:

a. Has a valid license,

b. Is eligible for further licensing, and

c. Is temporarily absent from Iowa or is temporarily incapacitated at the time for renewal.

605.15(2) Procedure. The licensee shall apply for an extension by submitting Form 430027 to the department. The form may be obtained from and submitted to a driver’s license service center. The licensee may also apply by letter to the address in paragraph 605.12(1)“a.”

a. A six-month extension shall be added to the expiration date on the license. When the licensee appears to renew the license, the expiration date of the renewed license will be computed from the expiration date of the original license, notwithstanding the extension.

b. The department shall allow only two six-month extensions.

This rule is intended to implement Iowa Code section 321.196.
[ARC 4000C, IAB 9/12/18, effective 10/17/18; ARC 5495C, IAB 3/10/21, effective 4/14/21]

761—605.16(321) Military extension.

605.16(1) *Form 430028.* A person who qualifies for a military extension of a valid license should request Form 430028 from the department and carry it with the license for verification to peace officers. Form 430028 explains the provisions of Iowa Code section 321.198 regarding military extensions.

605.16(2) *Request for retention of record.* A person with a military extension may request that the department retain the record of license issuance for the duration of the extension or reenter the record if it has been removed from department records. The request may be made by letter or by using Form 430081. The letter or Form 430081 shall be signed by the person's commanding officer to verify the military service and shall be submitted to the department at the address in paragraph 605.12(1) "a."

605.16(3) *Renewal of license after military extension.* When an applicant renews a license after a military extension, the department may require the applicant to provide documentation of both the military service and the date of separation from military service.

605.16(4) *Reinstatement after sanction.* A person with a military extension whose license has been canceled, suspended or revoked shall comply with the requirements of 761—615.40(321) to reinstate the license.

This rule is intended to implement Iowa Code section 321.198.
[ARC 4000C, IAB 9/12/18, effective 10/17/18]

761—605.17 to 605.19 Reserved.

761—605.20(321) Fee adjustment for upgrading license. The fee for upgrading a driver's license shall be computed on a full-year basis. The fee is charged for each year or part of a year between the date of the change and the expiration date on the license.

605.20(1) The fee to upgrade a driver's license from one class to another is determined by computing the difference between the current license fee and the new license fee as follows:

- a.* Converting noncommercial Class C to Class D—\$4 per year of new license validity.
- b.* Converting Class M to Class D with a motorcycle endorsement—\$4 per year of new license validity.
- c.* Converting Class M to noncommercial Class C with a motorcycle endorsement—\$2 one-time fee.

605.20(2) The fee to add a privilege to a driver's license is computed per year of new license validity as follows:

Noncommercial Class C (full privileges from a restricted Class C)	\$4 per year
Motorized bicycle	\$4 per year
Minor's restricted license	\$4 per year
Minor's school license	\$4 per year
Motorcycle instruction permit	\$2 per year
Motorcycle endorsement	\$2 per year

This rule is intended to implement Iowa Code sections 321.189 and 321.191.
[ARC 1714C, IAB 11/12/14, effective 12/17/14]

761—605.21 to 605.24 Reserved.

761—605.25(321) License renewal.

605.25(1) A licensee who wishes to renew a driver's license shall apply to the department and, if required, pass the appropriate examination.

605.25(2) A valid license may be renewed within 180 days before the expiration date. If this is impractical, the department for good cause may renew a license earlier.

605.25(3) A valid license may be renewed within 60 days after the expiration date, unless otherwise specified.

605.25(4) If the licensee's current residential address, name, date of birth, or sex designation has changed since the previous license was issued, the licensee shall comply with the following:

a. Current residential address. The licensee shall notify the department to establish the current residential address.

b. Name. The licensee shall comply with the requirements of 761—subrule 601.5(5) to establish a name change.

c. Date of birth. The licensee shall comply with the requirements of 761—subrule 601.5(6) to establish a change of date of birth.

d. Sex designation. The licensee shall comply with the requirements of 761—subrule 601.5(7) to establish a change of sex designation.

605.25(5) A licensee who has not previously been issued a license that may be accepted for federal identification purposes under 6 CFR Part 37 (a REAL ID license) and wishes to obtain a REAL ID license upon renewal must comply with the requirements of 761—601.5(321) to obtain a REAL ID license upon renewal.

605.25(6) A licensee who is a foreign national with temporary lawful status must provide documentation of lawful status as required by 761—subrule 601.5(4) at each renewal.

605.25(7) The department may determine means or methods for electronic renewal of a driver's license.

a. An applicant who meets the following criteria may apply for electronic renewal:

(1) The applicant must be at least 18 years of age but not yet 70 years of age.

(2) The applicant completed a satisfactory vision screen or submitted a satisfactory vision report under 761—subrules 604.10(1) to 604.10(3) and updated the applicant's photo at the applicant's last issuance or renewal.

(3) The applicant's driver's license has not been expired for more than one year.

(4) The department's records show the applicant is a U.S. citizen.

(5) The applicant's driver's license is not marked "valid without photo."

(6) The applicant is not seeking to change any of the following information as it appears on the applicant's driver's license:

1. Name.

2. Date of birth.

3. Sex.

(7) The applicant's driver's license is a Class C noncommercial driver's license, a Class D noncommercial driver's license (chauffeur), or Class M noncommercial driver's license (motorcycle) that is not a special license or permit, a temporary restricted license, or a two-year license.

(8) The applicant is not subject to a pending request for reexamination.

(9) The applicant does not wish to change any of the following:

1. Class of license.

2. License endorsements.

3. License restrictions.

(10) The applicant is not subject to any of the following restrictions:

G—No driving when headlights required

J—Restrictions on the back of card

T—Medical report required at renewal

8—Special instruction permit

Q—No interstate or freeway driving

R—Maximum speed of 35 mph

b. Notwithstanding any other provision of this subrule to the contrary, the department may accept an electronic renewal application if the license contains a single “J” restriction accompanied by a “7,” “I” or “Y” restriction.

c. The department reserves the right to deny electronic renewal and to require the applicant to personally apply for renewal at a driver’s license service center if it appears to the department that the applicant may have a physical or mental condition that may impair the applicant’s ability to safely operate a motor vehicle, even if the applicant otherwise meets the criteria in 605.25(7) “a.”

d. An applicant who has not previously been issued a driver’s license that is compliant with the REAL ID Act of 2005, 49 U.S.C. Section 30301 note, as further defined in 6 CFR Part 37 (a REAL ID license) may not request a REAL ID driver’s license by electronic renewal.

This rule is intended to implement Iowa Code sections 321.186 and 321.196, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[ARC 0347C, IAB 10/3/12, effective 11/7/12; ARC 0895C, IAB 8/7/13, effective 7/9/13; ARC 1073C, IAB 10/2/13, effective 11/6/13; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 4000C, IAB 9/12/18, effective 10/17/18]

761—605.26(321) Graduated driver’s license upgrades. An applicant subject to the graduated driver’s license requirements under Iowa Code section 321.180B who is otherwise eligible for a driver’s license is eligible to electronically apply to upgrade the applicant’s driver’s license under this rule.

605.26(1) Except for the requirements in subparagraphs 605.25(7) “a”(1) and 605.25(7) “a”(2), the applicant must meet the eligibility requirements listed in paragraph 605.25(7) “a” to upgrade the license electronically and must also meet the following criteria:

a. The applicant must have been issued an intermediate license under Iowa Code section 321.180B(2) or a minor’s school license under Iowa Code section 321.194 in person.

b. The applicant must otherwise be eligible to upgrade a license class privilege under Iowa Code section 321.180B or 321.194.

605.26(2) The requirements in paragraphs 605.25(7) “c” and 605.25(7) “d” shall also apply to a license issued under this rule.

605.26(3) If an applicant upgrades the applicant’s driver’s license electronically under this rule to a driver’s license with an eight-year expiration date, the applicant is ineligible to electronically renew the applicant’s full driver’s license at the next renewal period.

605.26(4) Notwithstanding any other provision of this rule to the contrary, the department may accept an electronic application to upgrade a license containing a “J” restriction if the “J” restriction is related only to a secondary address.

This rule is intended to implement Iowa Code sections 321.180B and 321.194.

[ARC 5495C, IAB 3/10/21, effective 4/14/21]

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[Filed ARC 5495C (Notice ARC 5384C, IAB 1/13/21), IAB 3/10/21, effective 4/14/21]

¹ Effective date of December 29, 1993, for 761—605.26(2)“a” and “d,” delayed 70 days by the Administrative Rules Review Committee at its meeting held December 15, 1993; delay lifted by this Committee on January 5, 1994, effective January 6, 1994.

CHAPTER 607
COMMERCIAL DRIVER LICENSING

761—607.1(321) Scope. This chapter applies to licensing persons for the operation of commercial motor vehicles. Unless otherwise stated, the provisions of this chapter are in addition to other motor vehicle licensing rules.

This rule is intended to implement Iowa Code chapter 321.

761—607.2(17A) Information.

607.2(1) Information and location. Applications, forms and information about the commercial driver's license (CDL) are available at any driver's license service center. Assistance is also available by mail from the Driver and Identification Services Bureau, Iowa Department of Transportation, P.O. Box 9204, Des Moines, Iowa 50306-9204; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (515)244-8725; by facsimile at (515)239-1837; or on the department's website at www.iowadot.gov.

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 service center and on the department's website.

This rule is intended to implement Iowa Code section 17A.3.

[ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 3689C, IAB 3/14/18, effective 4/18/18; ARC 4986C, IAB 3/11/20, effective 4/15/20]

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.

"Air over hydraulic brakes" means any braking system operating partially on the air brake and partially on the hydraulic brake principle.

"Automatic transmission" means any transmission other than a manual transmission.

"CDLIS" means "commercial driver's license information system" as defined in Iowa Code section 321.1.

"Commercial driver's license downgrade" or *"CDL downgrade"* means either:

1. The driver changes the driver's self-certification of type of driving from non-excepted interstate to excepted interstate, non-excepted intrastate, or excepted intrastate driving, or
2. The department removed the CDL privilege from the driver's license.

"Commercial motor vehicle" or *"CMV"* as defined in Iowa Code section 321.1 does not include a motor vehicle designed as off-road equipment rather than as a motor truck, such as a forklift, motor grader, scraper, tractor, trencher or similar industrial-type equipment. "Commercial motor vehicle" also does not include self-propelled implements of husbandry described in Iowa Code subsection 321.1(32).

"Controlled substance" as used in Iowa Code section 321.208 means a substance defined in Iowa Code section 124.101.

"Hazardous materials" means any material that has been designated as hazardous under 49 U.S.C. Section 5103 and is required to be placarded under 49 CFR Part 172, Subpart F, or any quantity of a material listed as a select agent or toxin in 42 CFR Part 73.

"Manual transmission" means a transmission utilizing a driver-operated clutch that is activated by a pedal or lever and a gear-shift mechanism operated either by hand or by foot. All other transmissions, whether semi-automatic or automatic, will be considered automatic.

"Medical examiner" means a person who is licensed, certified or registered, in accordance with applicable state laws and regulations, to perform physical examinations. The term includes but is not limited to doctors of medicine, doctors of osteopathy, physician assistants, advanced registered nurse practitioners, and doctors of chiropractic.

"Medical examiner's certificate" means a certificate completed and signed by a medical examiner under the provisions of 49 CFR Section 391.43.

“*Medical variance*” means a driver has received one of the following from the Federal Motor Carrier Safety Administration that allows the driver to be issued a medical certificate:

1. An exemption letter permitting operation of a commercial motor vehicle pursuant to 49 CFR Part 381, Subpart C, or 49 CFR Section 391.62, or 49 CFR Section 391.64.
2. A skill performance evaluation certificate permitting operation of a commercial motor vehicle pursuant to 49 CFR Section 391.49.

“*Passenger vehicle*” means either of the following:

1. A motor vehicle designed to transport 16 or more persons including the operator.
2. A motor vehicle of a size and design to transport 16 or more persons including the operator which is redesigned or modified to transport fewer than 16 persons with disabilities. The size of a redesigned or modified vehicle shall be any such vehicle with a gross vehicle weight rating of 10,001 or more pounds.

“*School bus*” means a commercial motor vehicle used to transport pre-primary, primary, or secondary school students from home to school, from school to home, or to and from school-sponsored events unless otherwise provided in Iowa Code section 321.1(69). “School bus” does not include a bus used as a common carrier.

“*Self-certification*” means a written certification of which category of type of driving an applicant for a commercial driver’s license engages in or intends to engage in, from the following categories:

1. Non-excepted interstate. The person certifies that the person operates or expects to operate in interstate commerce, is both subject to and meets the qualification requirements under 49 CFR Part 391, and is required to obtain a medical examiner’s certificate by 49 CFR Section 391.45.
2. Excepted interstate. The person certifies that the person operates or expects to operate in interstate commerce, but engages exclusively in transportation or operations excepted under 49 CFR Section 390.3(f), 391.2, 391.68 or 398.3 from all or parts of the qualification requirements of 49 CFR Part 391, and is therefore not required to obtain a medical examiner’s certificate by 49 CFR Section 391.45.
3. Non-excepted intrastate. The person certifies that the person operates only in intrastate commerce and is subject to state driver qualification requirements.
4. Excepted intrastate. The person certifies that the person operates only in intrastate commerce, but engages exclusively in transportation or operations excepted from all or parts of the state driver qualification requirements as set forth in Iowa Code section 321.449.

“*State,*” as used in this chapter and in “another state” in Iowa Code subsection 321.174(2), “former state of residence” in Iowa Code subsection 321.188(5), or “any state” in Iowa Code subsection 321.208(1), means one of the United States or the District of Columbia unless the context means the state of Iowa.

This rule is intended to implement Iowa Code sections 321.1, 321.174, 321.188, 321.191, 321.193, 321.207 and 321.208.

[ARC 7902B, IAB 7/1/09, effective 8/5/09; ARC 9954B, IAB 1/11/12, effective 1/30/12; ARC 0031C, IAB 3/7/12, effective 4/11/12; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.4 and **607.5** Reserved.

761—607.6(321) Exemptions.

607.6(1) *Persons exempt.* A person listed in Iowa Code section 321.176A is exempt from commercial driver licensing requirements.

607.6(2) *Exempt until April 1, 1992.* Rescinded IAB 6/23/93, effective 7/28/93.

This rule is intended to implement Iowa Code sections 321.1 and 321.176A.

761—607.7(321) Records. The operating record of a person who has been issued a commercial driver’s license or a commercial learner’s permit or a person who has been disqualified from operating

a commercial motor vehicle shall be maintained as provided in the department's "Record Management Manual" adopted in 761—Chapter 4.

This rule is intended to implement Iowa Code sections 22.11, 321.12 and 321.199.
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

761—607.8 and 607.9 Reserved.

761—607.10(321) Adoption of federal regulations.

607.10(1) Code of Federal Regulations. The department's administration of commercial driver's licenses shall be in compliance with the state procedures set forth in 49 CFR Section 383.73, and this chapter shall be construed to that effect. The department adopts the following portions of the Code of Federal Regulations which are referenced throughout this chapter of rules:

- a. 49 CFR Section 391.11 as adopted in 761—Chapter 520.
- b. 49 CFR Section 392.5 as adopted in 761—Chapter 520.
- c. 49 CFR Part 380, Subpart F.
- d. The following portions of 49 CFR Part 383 (October 1, 2019):
 - (1) Section 383.51, Disqualification of drivers.
 - (2) Subpart E—Testing and Licensing Procedures.
 - (3) Subpart G—Required Knowledge and Skills.
 - (4) Subpart H—Tests.

607.10(2) Copies of regulations. Copies of the federal regulations may be reviewed at the state law library or through the Internet at www.fmcsa.dot.gov.

This rule is intended to implement Iowa Code sections 321.187, 321.188, 321.207, 321.208 and 321.208A.

[ARC 7902B, IAB 7/1/09, effective 8/5/09; ARC 9954B, IAB 1/11/12, effective 1/30/12; ARC 0031C, IAB 3/7/12, effective 4/11/12; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 2986C, IAB 3/15/17, effective 4/19/17; ARC 3840C, IAB 6/6/18, effective 7/11/18; ARC 4401C, IAB 4/10/19, effective 5/15/19; ARC 4986C, IAB 3/11/20, effective 4/15/20; ARC 5018C, IAB 4/8/20, effective 5/13/20]

761—607.11 to 607.14 Reserved.

761—607.15(321) Application. An applicant for a commercial driver's license shall comply with the requirements of Iowa Code sections 321.180(2) "e," 321.182 and 321.188, and 761—Chapter 601, and must provide the proofs of citizenship or lawful permanent residence and state of domicile required by 49 CFR Section 383.71. If the applicant is domiciled in a foreign jurisdiction and applying for a nondomiciled commercial driver's license, the applicant must provide a document required by 49 CFR Section 383.71(f).

This rule is intended to implement Iowa Code sections 321.180, 321.182 and 321.188.
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

761—607.16(321) Commercial driver's license (CDL).

607.16(1) Classes. The department may issue a commercial driver's license only as a Class A, B or C driver's license. The license class identifies the types of vehicles that may be operated. A commercial driver's license may have endorsements which authorize additional vehicle operations or restrictions which limit vehicle operations.

607.16(2) Validity.

a. A Class A commercial driver's license allows a person to operate a combination of commercial motor vehicles as specified in Iowa Code section 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. Before the department administers the skills test for a Class A commercial driver's license to an applicant for the first time, the applicant must comply with the entry-level driver training requirements as provided in Iowa Code section 321.188.

b. A Class B commercial driver's license allows a person to operate a commercial motor vehicle as specified in Iowa Code section 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. Before the department administers the skills test for a Class B commercial driver's license to an applicant for the first time, the applicant must comply with the entry-level driver training requirements as provided in Iowa Code section 321.188.

c. A Class C commercial driver's license allows a person to operate a commercial motor vehicle as specified in Iowa Code paragraph 321.189(1) "c." With the required endorsements and subject to the applicable restrictions, a Class C commercial driver's license is valid to operate any vehicle except a truck-tractor semitrailer combination as a chauffeur (Class D) or a vehicle requiring a Class A or Class B commercial driver's license.

d. A commercial driver's license is valid for operating a motorcycle as a commercial motor vehicle only if the license has a motorcycle endorsement and a hazardous material endorsement. A commercial driver's license is valid for operating a motorcycle as a noncommercial motor vehicle only if the license has a motorcycle endorsement.

e. A commercial driver's license valid for eight years shall be issued to a qualified applicant who is at least 18 years of age but not yet 78 years of age. However, the expiration date of the license issued shall not exceed the licensee's 80th birthday.

f. A commercial driver's license valid for two years shall be issued to a qualified applicant 78 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 set out in 49 CFR, Part 391, Subpart B, except that, for a person operating solely intrastate, the driver age qualifications are set out in Iowa Code section 321.449(3).

b. The applicant shall meet the requirements set forth in rule 761—607.15(321).

607.16(4) Transition from five-year to eight-year licenses. During the period January 1, 2014, to December 31, 2018, the department shall issue qualified applicants otherwise eligible for an eight-year license a five-year, six-year, seven-year, or eight-year license, subject to all applicable limitations for age and ability. The applicable period shall be randomly assigned to the applicant by the department's computerized issuance system based on a distribution formula intended to spread renewal volumes as equally as practical over the eight-year period beginning January 1, 2019, and ending December 31, 2026.

607.16(5) License extension.

a. As provided in 49 CFR Section 383.153, a person may apply for a 60-day extension of a commercial driver's license if the person:

- (1) Has a valid license,
- (2) Is eligible for further licensing, and
- (3) Is temporarily absent from Iowa or is temporarily incapacitated at the time for renewal.

b. The person shall apply for an extension by submitting Form 430027 to the department. The form may be obtained from and submitted to a driver's license service center. The person may also apply by letter to the address in 761—paragraph 605.12(1) "a."

c. A 60-day extension shall be added to the expiration date on the license. When the person appears to renew the license, the expiration date of the renewed license will be computed from the expiration date of the original license, notwithstanding the extension.

d. The department shall allow only one 60-day extension.

This rule is intended to implement Iowa Code sections 321.177, 321.182, 321.188, 321.189, 321.196, and 321.449 and 2013 Iowa Acts, chapter 104, section 2.

[ARC 1714C, IAB 11/12/14, effective 12/17/14; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 4986C, IAB 3/11/20, effective 4/15/20; ARC 5495C, IAB 3/10/21, effective 4/14/21]

761—607.17(321) Endorsements. All endorsements except the hazardous material endorsement continue to be valid without retesting or additional fees when renewing or upgrading a license. The endorsements that authorize additional commercial motor vehicle operations with a commercial driver's license are:

607.17(1) Hazardous material. A hazardous material endorsement (H) is required to transport hazardous materials. The hazardous material endorsement is only valid when the applicant or holder of the endorsement complies with the Transportation Security Administration's security threat assessment standards specified in 49 CFR Sections 383.71(b)(8) and 383.141. Before the department administers the knowledge test for a hazardous material endorsement to an applicant for the first time, the applicant shall comply with the entry-level driver training requirements as provided in Iowa Code section 321.188. To obtain or retain the hazardous material endorsement, the applicant or holder must pass a knowledge test as required under 49 CFR Section 383.121 and pay the endorsement fee. Retesting and fee payment are also required when an applicant transfers a commercial driver's license from another state unless, as provided in 49 CFR Section 383.73, the transfer applicant provides evidence of passing the knowledge test as required under 49 CFR Section 383.121 within the preceding 24 months. A farmer or a person working for a farmer is not subject to the hazardous material endorsement while operating either a pickup or a special truck within 150 air miles of the farmer's farm to transport supplies to or from the farm.

607.17(2) Passenger vehicle. A passenger vehicle endorsement (P) is required to operate a passenger vehicle as defined in rule 761—607.3(321). Before the department administers the skills test for a passenger vehicle endorsement to an applicant for the first time, the applicant shall comply with the entry-level driver training requirements as provided in Iowa Code section 321.188.

607.17(3) Tank vehicle. A tank vehicle endorsement (N) is required to operate a tank vehicle as defined in Iowa Code section 321.1. A vehicle transporting a tank, regardless of the tank's capacity, which does not otherwise meet the definition of a commercial motor vehicle in Iowa Code section 321.1 is not a tank vehicle.

607.17(4) Double/triple trailer. A double/triple trailer endorsement (T) is required to operate a commercial motor vehicle with two or more towed trailers when the combination of vehicles meets the criteria for a Class A commercial motor vehicle. Operation of a triple trailer combination vehicle is not permitted in Iowa.

607.17(5) Hazardous material and tank. A combined endorsement (X) authorizes both hazardous material and tank vehicle operations.

607.17(6) School bus. A school bus endorsement (S) is required to operate a school bus as defined in rule 761—607.3(321). An applicant for a school bus endorsement must also qualify for a passenger vehicle endorsement. Before the department administers the skills test for a school bus endorsement to an applicant for the first time, the applicant shall comply with the entry-level driver training requirements as provided in Iowa Code section 321.188.

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, 321.188 and 321.189. [ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 4986C, IAB 3/11/20, effective 4/15/20]

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 605.8(3) and are explained below:

607.18(1) *Air brake.* The air brake restriction (L, no air brake equipped CMV) applies to a licensee who either fails the air brake component of the knowledge test or performs the skills test in a vehicle not equipped with air brakes and prohibits the operation of a commercial motor vehicle equipped with an air brake system until the licensee passes the required air brake tests and pays the fee for upgrading the license. Retesting and fee payment are not required when the license is renewed.

607.18(2) *Full air brake.* The full air brake restriction (Z, no full air brake equipped CMV) applies to a licensee who performs the skills test in a vehicle equipped with air over hydraulic brakes and prohibits the operation of a commercial motor vehicle equipped with any braking system operating fully on the air brake principle until the licensee passes the required air brake tests and pays the fee for upgrading the license. Retesting and fee payment are not required when the license is renewed.

607.18(3) *Manual transmission.* The manual transmission restriction (E, no manual transmission equipped CMV) applies to a licensee who performs the skills test in a vehicle equipped with automatic transmission and prohibits the operation of a commercial motor vehicle equipped with a manual transmission until the licensee passes the required tests and pays the fee for upgrading the license. Retesting and fee payment are not required when the license is renewed.

607.18(4) *Tractor-trailer.* The tractor-trailer restriction (O, no tractor trailer CMV) applies to a licensee who performs the skills test in a combination vehicle for a Class A commercial driver's license with the power unit and towed unit connected with a pintle hook or other non-fifth wheel connection and prohibits operation of a tractor-trailer combination connected by a fifth wheel that requires a Class A commercial driver's license until the licensee passes the required tests and pays the fee for upgrading the license. Retesting and fee payment are not required when the license is renewed.

607.18(5) *Class A passenger vehicle.* The Class A passenger vehicle restriction (M, no Class A passenger vehicle) applies to a licensee who applies for a passenger endorsement and performs the skills test in a passenger vehicle that requires a Class B commercial driver's license and prohibits operation of a passenger vehicle that requires a Class A commercial driver's license.

607.18(6) *Class A and B passenger vehicle.* The Class A and B passenger vehicle restriction (N, no Class A and B passenger vehicle) applies to a licensee who applies for a passenger endorsement and performs the skills test in a passenger vehicle that requires a Class C commercial driver's license and prohibits operation of a passenger vehicle that requires a Class A or Class B commercial driver's license.

607.18(7) *Intrastate only.* The intrastate only restriction (K, intrastate only) applies to a licensee who self-certifies to non-excepted intrastate or excepted intrastate driving and prohibits the operation of a commercial motor vehicle in interstate commerce.

607.18(8) *Medical variance.* The medical variance restriction (V, medical variance) applies to a licensee when the department is notified pursuant to 49 CFR Section 383.73(o)(3) that the driver has been issued a medical variance and indicates there is information about a medical variance on the CDLIS driver record.

This rule is intended to implement Iowa Code sections 321.189 and 321.191.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 4586C, IAB 7/31/19, effective 9/4/19]

761—607.19 Reserved.

761—607.20(321) Commercial learner's permit.

607.20(1) *Validity.*

a. A commercial learner's permit allows the permit holder to operate a commercial motor vehicle when accompanied as required by Iowa Code section 321.180(2) "d."

b. A commercial learner's permit is valid for one year without retaking the general and endorsement knowledge tests required by Iowa Code section 321.188.

c. A commercial learner's permit is invalid after the expiration date of the underlying commercial or noncommercial driver's license issued to the permit holder or the expiration date of the permit whichever occurs first.

d. The issuance of a commercial learner's permit is a precondition to the initial issuance of a commercial driver's license. The issuance of a commercial learner's permit is also a precondition to

the upgrade of a commercial driver's license if the upgrade requires a skills test. If the permit holder is subject to the requirement to complete entry-level driver training as provided in Iowa Code section 321.188, the permit holder shall complete the training after the permit holder obtains the commercial learner's permit, but before the permit holder takes the required skills test. The holder of a commercial learner's permit is not eligible to take a required driving skills test for the first 14 days after the permit holder is issued the permit. The 14-day period includes the day the commercial learner's permit was issued.

EXAMPLE: The commercial learner's permit is issued on September 1. The earliest date the permit holder would be eligible to take the skills test is September 15.

e. A commercial learner's permit is not valid for the operation of a vehicle transporting hazardous materials.

607.20(2) Requirements.

a. An applicant for a commercial learner's permit must hold a valid Class A, B, C, or D driver's license issued in this state that is not an instruction permit, a special instruction permit, a motorized bicycle license or a temporary restricted license; must be at least 18 years of age; and must meet the requirements to obtain a valid commercial driver's license, including the requirements set forth in Iowa Code section 321.188. However, the applicant does not have to complete the driving skills tests required for a commercial driver's license to obtain a commercial learner's permit.

b. The applicant must successfully pass a general knowledge test that meets the federal standards contained in 49 CFR Part 383, Subparts F, G and H, for the commercial motor vehicle the applicant operates or expects to operate, including any endorsement for which the applicant applies.

607.20(3) Endorsements. A commercial learner's permit may include the following endorsements. All other endorsements are prohibited on a commercial learner's permit.

a. An applicant for a passenger endorsement (P) must take and pass the passenger endorsement knowledge test. A commercial learner's permit holder with a passenger endorsement is prohibited from operating a commercial motor vehicle carrying passengers, other than federal/state auditors and inspectors, test examiners, other trainees, and the commercial driver's license holder accompanying the permit holder required by Iowa Code section 321.180(2) "d."

b. An applicant for a school bus endorsement (S) must take and pass the school bus endorsement knowledge test. A commercial learner's permit holder with a school bus endorsement is prohibited from operating a commercial motor vehicle carrying passengers, other than federal/state auditors and inspectors, test examiners, other trainees, and the commercial driver's license holder accompanying the permit holder required by Iowa Code section 321.180(2) "d."

c. An applicant for a tank vehicle endorsement (N) must take and pass the tank vehicle endorsement knowledge test. A commercial learner's permit holder with a tank vehicle endorsement may only operate an empty tank vehicle and is prohibited from operating any tank vehicle that previously contained hazardous materials that has not been purged of any residue.

607.20(4) Restrictions. A commercial learner's permit may include the air brake (L), medical variance (V), Class A passenger vehicle (M), Class A and B passenger vehicle (N) and intrastate only (K) restrictions described in rule 761—607.18(321). In addition, a commercial learner's permit may include the following restrictions that are specific to the commercial learner's permit:

a. Passenger. The passenger restriction (P, no passengers in CMV bus) applies to a permit holder who has a commercial learner's permit with a passenger or school bus endorsement and prohibits the operation of a commercial motor vehicle carrying passengers, other than federal/state auditors and inspectors, test examiners, other trainees, and the commercial driver's license holder accompanying the permit holder required by Iowa Code section 321.180(2) "d."

b. Cargo. The cargo restriction (X, no cargo in CMV tank vehicle) applies to a permit holder who has a commercial learner's permit with a tank vehicle endorsement and prohibits the operation of any

tank vehicle containing cargo or any tank vehicle that previously contained hazardous materials that has not been purged of any residue.

This rule is intended to implement Iowa Code sections 321.180, 321.186 and 321.188.
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 3689C, IAB 3/14/18, effective 4/18/18; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.21 to 607.24 Reserved.

761—607.25(321) Examination for a commercial driver's license. In addition to the requirements of 761—Chapter 604, an applicant for a commercial driver's license shall pass the knowledge and skills tests as required in 49 CFR Part 383, Subparts G and H.

This rule is intended to implement Iowa Code section 321.186.

761—607.26(321) Vision screening. An applicant for a commercial driver's license or commercial learner's permit must pass a vision screening test administered by the department. The vision standards are given in 761—604.11(321).

This rule is intended to implement Iowa Code sections 321.186 and 321.186A.
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

761—607.27(321) Knowledge tests.

607.27(1) General knowledge test. The general knowledge test for a commercial driver's license is a written test of topics such as vehicle inspection, operation, safety and control in accordance with 49 CFR Section 383.111.

607.27(2) Additional tests. In addition to the general knowledge test for a commercial driver's license, an additional knowledge test is required for each of the following:

- a. Class A license for combination vehicle operation as required in 49 CFR Section 383.111.
- b. Hazardous material endorsement as required in 49 CFR Section 383.121. The knowledge test for a hazardous material endorsement shall not be administered orally or in a language other than English.
- c. Passenger vehicle endorsement as required in 49 CFR Section 383.117.
- d. Tank vehicle endorsement as required in 49 CFR Section 383.119.
- e. Double/triple trailer endorsement as required in 49 CFR Section 383.115.
- f. School bus endorsement as required in 49 CFR Section 383.123. The applicant must also qualify for a passenger vehicle endorsement.
- g. Removal of the air brake restriction as required in 49 CFR Section 383.111.

607.27(3) Test methods. All knowledge tests shall be administered in compliance with 49 CFR Section 383.133(b). All tests other than the hazardous material endorsement test may be administered in written form, verbally, or in automated format and can be administered in a foreign language, provided no interpreter is used in administering the test. A verbal test shall be offered only at specified locations. Information about the locations is available at any driver's license service center.

607.27(4) Waiver. A waiver of any knowledge test is permitted only as provided in Iowa Code section 321.188(5) and this chapter. The burden of proof of having passed the hazardous material endorsement test within the preceding 24 months rests with the applicant.

607.27(5) Military waiver. The department may waive the requirement that an applicant pass a required knowledge test for an applicant who is a current or former military service member as defined in 49 CFR Section 383.5. An applicant for a waiver of the knowledge test under this subrule shall certify and provide evidence, as required by the department, that the following apply:

- a. The applicant is regularly employed or was regularly employed within the past year in a military position specifically designated in 49 CFR Section 383.77.
- b. The applicant is or was operating a vehicle representative of the commercial motor vehicle the applicant operates or expects to operate immediately preceding honorable separation from military service as evidenced by the applicant's certificate of release or discharge from active duty, commonly referred to as a DD form 214.
- c. The applicant has not had more than one driver's license, other than a military license.

- d.* The applicant has not had any driver's license suspended, revoked, or canceled.
- e.* The applicant has not been convicted of an offense committed while operating any type of motor vehicle that is listed as a disqualifying offense in 49 CFR Section 383.51(b).
- f.* The applicant has not had more than one conviction for an offense committed while operating any type of motor vehicle that is listed as a serious traffic violation in 49 CFR Section 383.51(c).
- g.* The applicant has not had a conviction for violation of a military, state, or local law relating to motor vehicle traffic control, other than a parking violation, arising in connection with any traffic accident, and has no record of an accident in which the applicant was at fault.

607.27(6) Requirement. An applicant must pass the applicable knowledge test(s) before taking the skills test. Passing scores for a knowledge test shall meet the standards contained in 49 CFR Section 383.135(a).

This rule is intended to implement Iowa Code sections 321.186 and 321.188.
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.28(321) Skills test.

607.28(1) Content. The skills test for a commercial driver's license is a three-part test as required in 49 CFR Part 383, Subparts E, G and H.

607.28(2) Test methods. All skills tests shall be administered in compliance with 49 CFR Section 383.133(c). Interpreters are prohibited during the administration of skills tests. Applicants must be able to understand and respond to verbal commands and instructions in English by a skills test examiner. Neither the applicant nor the examiner may communicate in a language other than English during the skills test.

607.28(3) Order. The skills test must be administered and successfully completed in the following order: pre-trip inspection, basic vehicle control skills, on-road skills. If an applicant fails one segment of the skills test, the applicant cannot continue to the next segment of the test, and scores for the passed segments of the test are only valid during initial issuance of the commercial learner's permit.

607.28(4) Vehicle. The applicant shall provide a representative vehicle for the skills test. "Representative vehicle" means a commercial motor vehicle that meets the statutory description for the class of license applied for.

a. To obtain a passenger vehicle endorsement applicable to a specific vehicle class, the applicant must take the skills test in a passenger vehicle, as defined in rule 761—607.3(321), satisfying the requirements of that class, as required in 49 CFR Section 383.117.

b. To obtain a school bus endorsement, the applicant must qualify for a passenger vehicle endorsement and take the skills test in a school bus, as defined in rule 761—607.3(321), in the same vehicle class as the applicant will drive, as required in 49 CFR Section 383.123.

c. To obtain a tank endorsement, the applicant must take the skills test in a representative vehicle for the class of license applied for, but the representative vehicle is not required to be a tank vehicle.

d. To remove an air brake or full air brake restriction, the applicant must take the skills test in a vehicle equipped with an air brake system, as defined in rule 761—607.3(321) and as required in 49 CFR Section 383.113.

e. To remove a manual transmission restriction, the applicant must take the on-road segment of the skills test in a vehicle equipped with a manual transmission, as defined in rule 761—607.3(321).

607.28(5) Skills test scoring. Passing scores for a skills test shall meet the standards contained in 49 CFR Section 383.135(b).

607.28(6) Military waiver. The department may waive the requirement that an applicant pass a required skills test for an applicant who is on active duty in the military service or who has separated from such service in the past year, provided the applicant meets the requirements of Iowa Code subsection 321.188(6).

607.28(7) Locations. The skills test for a commercial driver's license shall be given only at specified locations where adequate testing facilities are available. An applicant may contact any driver's license

service center for the location of the nearest skills testing center. 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.
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 3689C, IAB 3/14/18, effective 4/18/18; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.29(321) Waiver of skills test. Rescinded IAB 6/23/93, effective 7/28/93.

761—607.30(321) Third-party testing.

607.30(1) Purpose and definitions. The skills test required by rule 761—607.28(321) may be administered by third-party testers and third-party skills test examiners approved and certified by the department. For the purpose of administering third-party skills testing and this rule, the following definitions shall apply:

“*Community college*” means an Iowa community college established under Iowa Code chapter 260C.

“*Iowa-based motor carrier*” means a motor carrier or its subsidiary that has its principal place of business in the state of Iowa and operates a permanent commercial driver training facility in the state of Iowa.

“*Iowa nonprofit corporation*” means a nonprofit corporation that serves as a trade association for Iowa-based motor carriers.

“*Motor carrier*” means the same as defined in 49 CFR Section 390.5.

“*Permanent commercial driver training facility*” means a facility dedicated to a program of commercial driving instruction that is offered to employees or potential employees of the motor carrier as incident to the motor carrier’s commercial operations, that requires at least 40 hours of instruction, and that includes fixed and permanent structures and facilities for the off-road portions of commercial driving instruction, including classroom, pretrip inspection, and basic vehicle control skills. A permanent commercial driver training facility must include a fixed and paved or otherwise hard-surfaced area for basic vehicle control skills testing that is permanently marked and capable of inspection and measurement by the department.

“*Skills test*” means the skills test required by rule 761—607.28(321).

“*Subsidiary*” means a company that is partly or wholly owned by a motor carrier that holds a controlling interest in the subsidiary company.

“*Third-party skills test examiner*” means the same as defined in 49 CFR Section 383.5.

“*Third-party tester*” means the same as defined in 49 CFR Section 383.5.

607.30(2) Certification of third-party testers.

a. The department may certify as a third-party tester a community college, Iowa-based motor carrier or Iowa nonprofit corporation to administer skills tests. A community college, Iowa-based motor carrier or Iowa nonprofit corporation that seeks certification as a third-party tester shall contact the driver and identification services bureau and schedule a review of the proposed testing program, which shall include the proposed testing courses and facilities, information sufficient to identify all proposed third-party skills test examiners, and any other information necessary to demonstrate compliance with 49 CFR Section 383.75.

b. No community college, Iowa-based motor carrier or Iowa nonprofit corporation shall be certified to conduct third-party testing unless and until the community college, Iowa-based motor carrier or Iowa nonprofit corporation enters an agreement with the department that meets the requirements of 49 CFR Section 383.75 and demonstrates sufficient ability to conduct skills tests in a manner that consistently meets the requirements of 49 CFR Section 383.75.

c. The department shall issue a certified third-party tester a certificate of authority that identifies the classes and types of vehicles for which skills tests may be administered. The certificate shall be valid for the duration of the agreement executed pursuant to paragraph 607.30(2) “b,” unless revoked by the department for engaging in fraudulent activities related to conducting skills tests or failing to comply

with the requirements, qualifications, and standards of this chapter, the agreement, or 49 CFR Section 383.75.

607.30(3) Certification of third-party skills test examiners.

a. A certified third-party tester shall not employ or otherwise use as a third-party skills test examiner a person who has not been approved and certified by the department to administer skills tests. Each certified third-party tester shall submit for approval the names of all proposed third-party skills test examiners to the department. The department shall not approve as a third-party skills test examiner a person who does not meet the requirements, qualifications and standards of 49 CFR Sections 383.75 and 384.228, including but not limited to all required training and examination and a nationwide criminal background check. The criteria for passing the nationwide criminal background check shall include no felony convictions within the last ten years and no convictions involving fraudulent activities.

b. The department shall issue a certificate of authority for each person certified as a third-party skills test examiner that identifies the certified third-party tester for which the person will administer skills tests and the classes and types of vehicles for which the person may administer skills tests. The certificate shall be valid for a period of four years from the date of issuance of the certificate.

c. The department shall revoke the certificate if the person holding the certificate does not administer skills tests to at least ten different applicants per calendar year; does not successfully complete the refresher training required by 49 CFR Section 384.228 every four years; is involved in fraudulent activities related to conducting skills tests; or otherwise fails to comply with and meet the requirements, qualifications and standards of this chapter or 49 CFR Sections 383.75 and 384.228. Notwithstanding anything in this paragraph to the contrary, as provided in 49 CFR Section 383.75, if the person does not administer skills tests to at least ten different applicants per calendar year, the certificate will not be revoked for that reason if the person provides proof of completion of the examiner refresher training in 49 CFR Section 384.228 to the department or successfully completes one skills test under the observation of a department examiner.

d. A third-party skills test examiner who is also a skills instructor shall not administer a skills test to an applicant who received skills training from that third-party skills test examiner.

e. A third-party skills test examiner may only administer CDL skills tests for the examiner's primary employer, unless authorized by the department to administer CDL skills tests for another county or third-party tester.

607.30(4) Bond. As a condition of certification, an Iowa-based motor carrier or Iowa nonprofit corporation must maintain a bond in the amount of \$50,000 to pay for the retesting of drivers in the event that the third-party tester or one or more of its third-party skills test examiners are involved in fraudulent activities related to conducting skills tests of applicants for a commercial driver's license.

607.30(5) Limitation applicable to Iowa-based motor carriers. An Iowa-based motor carrier certified as a third-party tester may only administer the skills test to persons who are enrolled in the Iowa-based motor carrier's commercial driving instruction program and shall not administer skills tests to persons who are not enrolled in that program.

607.30(6) Training and refresher training for third-party skills test examiners. All training and refresher training required under this rule shall be provided by the department, in form and content that meet the recommendations of the American Association of Motor Vehicle Administrators' International Third-Party Examiner/Tester Certification Program.

This rule is intended to implement Iowa Code section 321.187.

[ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.31(321) Test results.

607.31(1) Period of validity. Passing knowledge and skills test results shall remain valid for a period of one year.

607.31(2) Retesting. Subject to rule 761—607.28(321), an applicant shall be required to repeat only the knowledge test(s) or part(s) of the skills test that the applicant failed. An applicant who fails a test shall not be permitted to repeat that test the same day. An applicant may be required to repeat a test if the department determines the test was improperly administered.

607.31(3) Skills test results from other states. As required by 49 CFR Section 383.79, the department shall accept the valid results of a skills test administered to an applicant who is domiciled in the state of Iowa and that was administered by another state, in accordance with 49 CFR Part 383, Subparts F, G and H, in fulfillment of the applicant's testing requirements under 49 CFR Section 383.71 and the state's test administration requirements under 49 CFR Section 383.73. The results must be transmitted directly from the testing state to the department as required by 49 CFR Section 383.79.

607.31(4) Skills test results from certified third-party testers. A third-party skills tester certified under rule 761—607.30(321) shall transmit the skills test results of tests administered by the third-party tester through secure electronic means determined by the department. The department may retest any person who has passed a skills test administered by a certified third-party tester if it appears to the department that the skills test administered by the third-party tester was administered fraudulently or improperly, and as needed to meet the third-party skills test examiner oversight requirements of 49 CFR Section 383.75(a)(5).

This rule is intended to implement Iowa Code sections 321.180, 321.186, 321.187 and 321.188. [ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 3689C, IAB 3/14/18, effective 4/18/18; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.32(321) Knowledge and skills testing of nondomiciled military personnel.

607.32(1) Role of state of duty station. The department may accept an application for a CLP or CDL, including an application for waiver of the knowledge test as provided in subrule 607.27(5), if the applicant is an active duty military service member stationed, but not domiciled, in Iowa, and the department has an agreement to accept such applications with the applicant's state of domicile as provided in 49 CFR Section 383.79.

a. The applicant shall certify and provide evidence that the following apply:

- (1) The applicant is regularly employed or was regularly employed within the past year in a military position requiring operation of a commercial motor vehicle.
- (2) The applicant has a valid driver's license from the applicant's state of domicile.
- (3) The applicant has a valid active duty military identification card.
- (4) The applicant has a current copy of either the applicant's military leave and earnings statement or the applicant's orders.

b. If the applicant meets the requirements of paragraph 607.32(1) "a" and the department has an agreement with the applicant's state of domicile as provided in this subrule, the department may do either of the following:

- (1) Administer the knowledge and skills tests to the applicant as appropriate in accordance with 49 CFR Part 383, Subparts F, G, and H, if the state of domicile requires those tests; or
- (2) Waive the knowledge and skills tests in accordance with 49 CFR Section 383.77 and this chapter if the state of domicile also permits waiver of the knowledge and skills test.

c. The department may destroy the applicant's driver's license on behalf of the state of domicile unless the state of domicile requires the driver's license to be surrendered to the state of domicile's driver's licensing agency.

607.32(2) Electronic transmission of application and test results. The department shall transmit to the state of domicile the applicant's application, any supporting documents and the results of any skills or knowledge tests administered as provided under this rule.

607.32(3) Role of state of domicile. If the department has an agreement with the applicant's state of duty station, upon completion of the applicant's application pursuant to 49 CFR Section 383.71 and any testing administered by the applicant's state of duty station pursuant to 49 CFR Sections 383.71 and 383.73, the department may do all of the following:

- a.* Accept the completed application, any supporting documents, and the results of the knowledge and skills tests administered by the applicant's state of duty station.
- b.* Issue the applicant a CLP or CDL.

This rule is intended to implement Iowa Code sections 321.180, 321.186, 321.187, and 321.188 and 49 CFR Part 383.

[ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.33 and **607.34** Reserved.

761—607.35(321) Issuance of commercial driver's license and commercial learner's permit. A commercial driver's license or commercial learner's permit issued by the department shall include the information and markings required by Iowa Code section 321.189(2) "b."

This rule is intended to implement Iowa Code section 321.189.
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

761—607.36(321) Conversion to commercial driver's license. Rescinded IAB 6/23/93, effective 7/28/93.

761—607.37(321) Commercial driver's license renewal. The department shall administer commercial driver's license renewals as required by 49 CFR Section 383.73.

607.37(1) Licensee requirements. To renew a commercial driver's license, the licensee shall apply at a driver's license service center and complete the following requirements:

a. The licensee shall make a written self-certification of type of driving as required by rule 761—607.50(321) and provide a current medical examiner's certificate if required.

b. If the licensee has and wishes to retain a hazardous material endorsement, the licensee shall pass the test required in 49 CFR Section 383.121 and comply with the Transportation Security Administration security threat assessment standards specified in 49 CFR Sections 383.71(b)(8) and 383.141 for such endorsement. A lawful permanent resident of the United States must also provide the licensee's U.S. Citizenship and Immigration Services alien registration number.

c. The licensee shall provide proof of citizenship or lawful permanent residency and state of domicile as required by rule 761—607.15(321) and 49 CFR 383.73(d)(7). Proof of citizenship or lawful permanent residency is not required if the licensee provided such proof at initial issuance or a previous renewal or upgrade of the license and the department has a notation on the licensee's record confirming that the required proof of legal citizenship or legal presence check was made and the date on which it was made.

d. If the licensee is domiciled in a foreign jurisdiction and renewing a non-domiciled commercial driver's license, the licensee must provide a document required by 49 CFR 383.71(f) at each renewal.

607.37(2) Early renewal. A valid commercial driver's license may be renewed 90 days before the expiration date. If this is impractical, the department for good cause may renew a license earlier, not to exceed 364 days prior to the expiration date. The department may allow renewal earlier than 364 days prior to the expiration date for active military personnel being deployed due to actual or potential military conflict.

This rule is intended to implement Iowa Code sections 321.186, 321.188 and 321.196.
[ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 4986C, IAB 3/11/20, effective 4/15/20]

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(12), 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.*

a. As permitted by 49 CFR Section 383.51, a person subject to lifetime disqualification of the person's commercial driving privileges may apply to the department for reinstatement. The approval is subject to the discretion of the department and subject to the following requirements:

(1) The request may not be made prior to ten years from the effective date of the lifetime disqualification.

(2) The person must submit the request in a manner prescribed by the department.

(3) If the driving record contains alcohol-related or drug-related offenses that resulted in the lifetime disqualification, the person must have completed an alcohol or drug evaluation and have completed any recommended treatment which meets or exceeds the minimum standards approved by the Iowa department of public health. Evidence of a completed evaluation and treatment must be on file with the department or submitted with the application for reinstatement.

(4) Within the ten years preceding the request, the person must not have any of the following moving violation convictions:

1. A drug or alcohol offense.

2. Leaving the scene of an accident.

3. A felony involving the use of any motor vehicle.

4. Any moving violation while operating a commercial motor vehicle.

(5) The department may request, and the person shall provide, any additional information or documentation necessary to determine the person's eligibility for reinstatement or general fitness for licensure.

b. If the department finds the person is eligible for reinstatement under this subrule, the person shall do all of the following prior to reinstatement:

(1) Pay all outstanding reinstatement fees.

(2) Meet all outstanding reinstatement requirements.

(3) Pass the required knowledge, vision, and skills tests as specified in Iowa Code section 321.188.

(4) Complete any other courses or requirements as required by the director.

c. As provided in 49 CFR Section 383.51(a)(6), a person who has previously had the person's commercial driving privileges reinstated pursuant to this subrule shall not be eligible to apply for reinstatement following conviction of a subsequent disqualifying offense.

d. If the department determines the person is not eligible for reinstatement as provided in this subrule, the department shall send notice by first-class mail to the person's mailing address as shown on departmental records that the lifetime disqualification remains in effect.

607.39(5) *Fraud related to testing and issuance.*

a. As required by 49 CFR Section 383.73(k) and Iowa Code section 321.201(2)"*b*," the department shall disqualify the commercial driver's license or commercial learner's permit of a person convicted or suspected of fraud related to the testing for or issuance of a commercial driver's license or commercial learner's permit.

b. Upon receipt of a person's conviction of fraud related to the issuance of the commercial driver's license or commercial learner's permit, the department shall disqualify the person's commercial driver's license or commercial learner's permit for one year.

c. Upon receipt of credible evidence that a person is suspected of committing fraud relating to the issuance of a commercial driver's license or a commercial learner's permit, the department shall notify the person of the requirement to retake the applicable knowledge or skills test. Within 30 days of receiving notice from the department, the person is required to contact the department to retake the knowledge or skills test. If the person fails to contact the department within 30 days after the notice, or the person fails the knowledge or skills test, or does not take the test, the department shall disqualify the person's commercial driver's license or commercial learner's permit.

d. Once a person's commercial driver's license or commercial learner's permit has been disqualified, the person must reapply following the usual procedures as provided in Iowa Code section 321.188 and this chapter.

This rule is intended to implement Iowa Code chapter 17A and section 321.208.
[ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 4986C, IAB 3/11/20, effective 4/15/20]

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 service center. 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.
[ARC 4986C, IAB 3/11/20, effective 4/15/20]

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 an unrestricted commercial driver's license 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, drag racing, or eluding or attempting to elude a law enforcement officer.

(6) Improper or erratic lane changes.

(7) Following too closely.

(8) A moving violation that contributed to a motor vehicle accident.

(9) A violation deemed serious under rule 761—615.17(321).

d. No record of contributive accidents, as defined in rule 761—615.1(321).

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 period of 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. On or after January 1, 2017, a licensee may have up to three individual periods of validity for a restricted commercial driver's license, provided the cumulative period of validity for all individual periods does not exceed 180 days in any calendar year. An individual period of validity may be 60, 90, or 180 consecutive days, at the election of the licensee. A licensee may add 30 days to an individual period of validity by applying for an extension, subject to the 180-day cumulative maximum period of validity. A request for extension must be made no later than the date of expiration of the individual period of validity for which an extension is requested; a request for extension made after that date shall be treated as a request for a new individual period of validity. An extension shall be calculated from the date of expiration of the individual period of validity for which an extension is requested. Any period of validity authorized previously by another state's license shall be considered a part of the 180-day cumulative maximum period of validity.

g. A restricted commercial driver's license must be validated for commercial motor vehicle operation for each individual period of validity. This means that the applicant/licensee must have the person's good driving record confirmed at each application for an individual period of validity. Upon confirmation, the department shall issue a replacement license with a restriction validating the license for that individual period of validity, 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 individual period of validity within a calendar year.

This rule is intended to implement Iowa Code section 321.176B.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.50(321) Self-certification of type of driving and submission of medical examiner's certificate.

607.50(1) *Applicants for commercial learner's permit, restricted CDL, or new, transferred, renewed or upgraded CDL.*

a. A person shall provide to the department a self-certification of type of driving if the person is applying for:

- (1) A commercial learner's permit,
- (2) An initial commercial driver's license,
- (3) A transfer of a commercial driver's license from a prior state of domicile to the state of Iowa,
- (4) Renewal of a commercial driver's license,
- (5) A license upgrade for a commercial driver's license or an endorsement authorizing the operation of a commercial motor vehicle not covered by the current commercial driver's license, or
- (6) A restricted 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) *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(3) *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(4) *CDL downgrade.* If the medical examiner's certificate or medical variance for a person self-certifying to non-excepted interstate driving expires or if the Federal Motor Carrier Safety Administration notifies the department that the person's medical variance was removed or rescinded, the department shall post a medical certification status of "not certified" to the person's CDLIS driver's record and shall initiate a downgrade of the person's commercial driver's license or commercial learner's permit. The medical examiner's certificate of a person who fails to maintain a medical certification status of "certified" as required by subrule 607.50(3) shall be deemed to be expired on the date of expiration of the last medical examiner's certificate filed for the person as shown by the person's CDLIS driver's record. The downgrade will be initiated and completed as follows:

a. The department shall give the person written notice that the person's medical certification status is "not certified" and that the commercial motor vehicle privileges will be removed from the person's commercial driver's license or commercial learner's permit 60 days after the date the medical examiner's certificate or medical variance expired or the medical variance was removed or rescinded unless the person submits to the department a current medical certificate or medical variance or self-certifies to a type of driving other than non-excepted interstate.

b. If the person submits a current medical examiner's certificate or medical variance before the end of the 60-day period, the department shall post a medical certification status of "certified" on the person's CDLIS driver's record and shall terminate the downgrade of the person's commercial driver's license or commercial learner's permit.

c. If the person self-certifies to a type of driving other than non-excepted interstate before the end of the 60-day period, the department shall not remove the commercial motor vehicle privileges from the person's commercial driver's license or commercial learner's permit, and the person will have no medical certification status on the person's CDLIS driver's record.

d. If the person fails to take the action in either paragraph 607.50(4) “*b*” or “*c*” before the end of the 60-day period, the department shall remove the commercial motor vehicle privileges from the person’s commercial driver’s license or commercial learner’s permit and shall leave the person’s medical certification status as “not certified” on the person’s CDLIS driver’s record.

607.50(5) *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(6) *Reestablishment of the CDL privilege.* A person whose commercial motor vehicle privileges have been removed from the person’s commercial driver’s license or commercial learner’s permit under the provisions of paragraph 607.50(4) “*d*” may reestablish the commercial motor vehicle privileges by either of the following methods:

a. Submitting a current medical examiner’s certificate or medical variance to the department. A person who has failed to self-certify to a type of driving must also make an initial self-certification of type of driving to non-excepted interstate driving. The department shall then post a medical certification status of “certified” on the person’s CDLIS driver’s record and reestablish the commercial motor vehicle privileges, provided that the person otherwise remains eligible for a commercial driver’s license or commercial learner’s permit.

b. Self-certifying to a type of driving other than non-excepted interstate. The department shall then reestablish the commercial motor vehicle privileges, provided that the person otherwise remains eligible for a commercial driver’s license or commercial learner’s permit; the person will have no medical certification status on the driver’s CDLIS driver’s record.

607.50(7) *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(2), 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(8) *Record keeping.* The department shall comply with the medical record-keeping requirements set forth in 49 CFR Section 383.73.

This rule is intended to implement Iowa Code sections 321.182, 321.188 and 321.207.

[ARC 9954B, IAB 1/11/12, effective 1/30/12; ARC 0031C, IAB 3/7/12, effective 4/11/12; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.51(321) Determination of gross vehicle weight rating.

607.51(1) *Actual weight prohibited.* In determining whether the vehicle is a representative vehicle for the skills test and the group of commercial driver’s license for which the applicant is applying, the vehicle’s gross weight rating or gross combination weight rating must be used, not the vehicle’s actual gross weight or gross combination weight. For purposes of this rule, “gross weight rating” and “gross combination weight rating” mean as defined in 49 CFR Section 383.5.

607.51(2) *Vehicle without legible manufacturer’s certification label.* To complete a skills test using a vehicle that has no legible manufacturer’s certification label, whether a power unit or towed vehicle, the applicant must provide documentation of the vehicle’s gross vehicle weight rating, such as a manufacturer’s certificate of origin, a title, or the vehicle identification number information for the vehicle. In the absence of such documentation, the vehicle may not be used, either alone or in combination.

This rule is intended to implement Iowa Code section 321.1.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

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CHAPTER 615
SANCTIONS

[Prior to 6/3/87, Transportation Department[820]—(07,C) Ch 6]

761—615.1(321) Definitions. The definitions in 761—600.1(321) apply to this chapter. In addition:

“*Accident free*” as used in Iowa Code section 321.180B means the driver has not been involved in a contributive accident. “*Involvement in a motor vehicle accident*” as used in Iowa Code section 321.180B means involvement in a contributive accident.

“*Contributive accident*” or “*contributed to an accident*” means the driver was involved in an accident for which there is evidence in departmental records that the driver performed an act which resulted in or contributed to the accident or failed to perform an act which would have avoided or contributed to the avoidance of the accident.

“*Deny*” or “*denial*” means a rejection of an application for a license or a refusal to issue, renew or reinstate a license.

“*Moving violation,*” unless otherwise provided in this chapter, means any violation of motor vehicle laws except:

1. Violations of equipment standards to be maintained for motor vehicles.
2. Parking violations as defined in Iowa Code section 321.210.
3. Child restraint and safety belt and harness violations under Iowa Code sections 321.445 and 321.446.
4. Violations of registration, weight and dimension laws.
5. Operating with an expired license.
6. Failure to appear.
7. Disturbing the peace with a motor vehicle.
8. Violations of Iowa Code section 321.20B for failure to provide proof of financial liability coverage.

“*Sanction*” means a license denial, cancellation, suspension, revocation, bar or disqualification.

This rule is intended to implement Iowa Code sections 321.1, 321.178, 321.180A, 321.189, 321.194, 321.210, 321.215, 321.445, 321.446 and 321.555.

[ARC 4119C, IAB 11/7/18, effective 12/12/18]

761—615.2(321) Scope. This chapter of rules applies to any license, as defined in 761—600.1(321). However:

615.2(1) Rules specifically addressing denial, cancellation or disqualification of a commercial driver’s license are found in 761—Chapter 607, “Commercial Driver Licensing.”

615.2(2) Rules implementing Iowa Code chapter 321J are found in 761—Chapter 620, “OWI and Implied Consent.”

615.2(3) Rules implementing Iowa Code chapter 321A are found in 761—Chapter 640, “Financial Responsibility.”

This rule is intended to implement Iowa Code chapters 321, 321A and 321J.

761—615.3(17A) Information and address. Applications, forms and information concerning license sanctions are available at any driver’s license service center. Assistance is also available by mail from the Driver and Identification Services Bureau, Iowa Department of Transportation, P.O. Box 9204, Des Moines, Iowa 50306-9204; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (515)244-8725; by facsimile at (515)239-1837; or on the department’s website at www.iowadot.gov.

This rule is intended to implement Iowa Code section 17A.3.

[ARC 4119C, IAB 11/7/18, effective 12/12/18; ARC 5496C, IAB 3/10/21, effective 4/14/21]

761—615.4(321) Denial for incapability.

615.4(1) A person who has a valid Iowa license that would otherwise be suspended for incapability shall, in lieu of a suspension, be denied further licensing if there is less than 30 days’ validity on the license.

- a. The denial shall be effective when the license is no longer valid.
- b. The license shall be surrendered to the department. The department shall issue a temporary driving permit which allows the person to drive until the effective date of the denial.

615.4(2) If a person who is denied licensing for incapability does not have a valid Iowa license, the department may refuse orally to issue a license, effective immediately, or may deny licensing in writing, effective on the date the denial notice is served.

This rule is intended to implement Iowa Code sections 321.177 and 321.210.

761—615.5 and 615.6 Reserved.

761—615.7(321) Cancellations.

615.7(1) The department shall cancel the license of an unmarried minor upon receipt of a written withdrawal of consent from the person who consented to the minor's application. The department shall also cancel a minor's license upon receipt of evidence of the death of the person who consented to the minor's application.

615.7(2) The department shall cancel a motorized bicycle license when the licensee is convicted of one moving violation. Reapplication may be made 30 days after the date of cancellation.

615.7(3) The department may cancel a license when the person was not entitled or is no longer entitled to a license, failed to give correct and required information, or committed fraud in applying.

615.7(4) A cancellation shall begin ten days after the department's notice of cancellation is served.

This rule is intended to implement Iowa Code sections 321.184, 321.185, 321.189, 321.201 and 321.215.

761—615.8 Reserved.

761—615.9(321) Habitual offender.

615.9(1) The department shall declare a person to be a habitual offender under Iowa Code section 321.555(1) in accordance with the following point system:

- a. Points shall be assigned to convictions as follows:

<u>Conviction</u>	<u>Points</u>
Perjury or the making of a false affidavit or statement under oath to the department of public safety	2 points
Driving while under suspension, revocation or denial (except Iowa Code chapter 321J)	2 points
Driving while under Iowa Code chapter 321J revocation or denial	3 points
Driving while barred	4 points
Operating a motor vehicle in violation of Iowa Code section 321J.2	4 points
An offense punishable as a felony under the motor vehicle laws of Iowa or any felony in the commission of which a motor vehicle is used	5 points
Failure to stop and leave information or to render aid as required by Iowa Code sections 321.261 and 321.263	5 points
Eluding or attempting to elude a pursuing law enforcement vehicle in violation of Iowa Code section 321.279	5 points
Serious injury by a vehicle in violation of Iowa Code section 707.6A(4)	5 points
Manslaughter resulting from the operation of a motor vehicle	6 points

- b. Based on the points accumulated, the person shall be barred from operating a motor vehicle on the highways of this state as follows:

<u>Points</u>	<u>Length of bar</u>
6 – 7	2 years
8 – 9	3 years
10 – 12	4 years
13 – 15	5 years
16+	6 years

615.9(2) A person declared to be a habitual offender under Iowa Code subsection 321.555(2) shall be barred from operating a motor vehicle on the highways of this state for one year.

615.9(3) A person declared to be a habitual offender under Iowa Code section 321.560 shall be barred from operating a motor vehicle on the highways of this state beginning on the date the previous bar expires.

This rule is intended to implement Iowa Code sections 321.555, 321.556 and 321.560.
[ARC 4119C, IAB 11/7/18, effective 12/12/18]

761—615.10 Reserved.

761—615.11(321) Periods of suspension or revocation.

615.11(1) *Length.* The department shall not suspend or revoke a person’s license for less than 30 days nor for more than one year unless a statute specifies or permits a different period of suspension or revocation.

615.11(2) *Extension of suspension or revocation.* The department shall extend the period of license suspension or revocation for an additional like period or for one year, whichever period is shorter, when the person is convicted of operating a motor vehicle while the person’s license is suspended or revoked, unless a statutory exception applies. If the person’s driving record does not indicate what the original grounds for suspension or revocation were, the period of license suspension or revocation shall not exceed six months.

This rule is intended to implement Iowa Code sections 321.212 and 321.218.
[ARC 4119C, IAB 11/7/18, effective 12/12/18]

761—615.12(321) Suspension of a habitually reckless or negligent driver.

615.12(1) The department may suspend a person’s license if the person is a habitually reckless or negligent driver of a motor vehicle. “Habitually reckless or negligent driver” means a person who has accumulated a combination of three or more contributive accidents and convictions for moving violations or three or more contributive accidents within a 12-month period.

615.12(2) In this rule, speeding violations specified in Iowa Code section 321.210(2)“d” and violations under Iowa Code section 321.276 are not included.

615.12(3) The suspension period shall be at least 60 days.

This rule is intended to implement Iowa Code section 321.210.
[ARC 4119C, IAB 11/7/18, effective 12/12/18]

761—615.13(321) Suspension of a habitual violator.

615.13(1) The department may suspend a person’s license when the person is a habitual violator of the traffic laws. “Habitual violator” means that the person has been convicted of three or more moving violations committed within a 12-month period.

615.13(2) The minimum suspension periods shall be as follows unless reduced by a driver’s license hearing officer based on mitigating circumstances:

3 convictions in 12 months	90 days
4 convictions in 12 months	120 days
5 convictions in 12 months	150 days
6 convictions in 12 months	180 days
7 or more convictions in 12 months	1 year

615.13(3) In this rule, speeding violations specified in Iowa Code section 321.210(2)“d” and violations under Iowa Code section 321.276 are not included.

This rule is intended to implement Iowa Code section 321.210.
[ARC 4119C, IAB 11/7/18, effective 12/12/18]

761—615.14(321) Suspension for incapability. The department may suspend a person’s license when the person is incapable of safely operating a motor vehicle.

615.14(1) Suspension for incapability may be based on one or more of the following:

a. Receipt of a medical report stating that the person is not physically or mentally capable of safely operating a motor vehicle.

b. Failure of the person to appear for a required reexamination or failure to submit a required medical report within the specified time.

c. Ineligibility for licensing under Iowa Code sections 321.177(4) to 321.177(7).

615.14(2) The suspension period shall be indefinite but shall be terminated when the department receives satisfactory evidence that the licensee has been restored to capability.

615.14(3) A person whose license has been suspended for incapability may be eligible for a special noncommercial instruction permit under rule 761—602.21(321).

This rule is intended to implement Iowa Code sections 321.177, 321.210, and 321.212.
[ARC 4119C, IAB 11/7/18, effective 12/12/18]

761—615.15(321) Suspension for unlawful use of a license.

615.15(1) The department may suspend a person’s license when the person has been convicted of unlawful or fraudulent use of the license or if the department has received other evidence that the person has violated Iowa Code section 321.216, 321.216A, 321.216B or 321.216C.

615.15(2) The suspension period shall be at least 30 days.

615.15(3) A suspension for a violation of Iowa Code section 321.216B shall not exceed six months.

This rule is intended to implement Iowa Code sections 321.210, 321.212, 321.216, 321.216A, 321.216B and 321.216C.

[ARC 5496C, IAB 3/10/21, effective 4/14/21]

761—615.16(321) Suspension for out-of-state offense. The department may suspend a person’s license when the department is notified by another state that the person committed an offense in that state which, if committed in Iowa, would be grounds for suspension. The notice may indicate either a conviction or a final administrative decision. The period of the suspension shall be the same as if the offense had occurred in Iowa.

This rule is intended to implement Iowa Code sections 321.205 and 321.210.

761—615.17(321) Suspension for a serious violation.

615.17(1) The department may suspend a person’s license when the person has committed a serious violation of the motor vehicle laws.

615.17(2) “Serious violation” means that:

a. The person’s conviction for a moving violation was accompanied by a written report from the arresting officer, the prosecuting attorney or the court indicating that the violation was unusually serious. The suspension period shall be at least 60 days.

b. The person was convicted of a moving violation which contributed to a fatal motor vehicle accident. The suspension period shall be at least 120 days.

c. The person was convicted for speeding 25 miles per hour (mph) or more above the legal limit. The minimum suspension period shall be as follows unless reduced by a driver's license hearing officer based on mitigating circumstances:

25 mph over the legal limit	60 days
26 mph over the legal limit	65 days
27 mph over the legal limit	70 days
28 mph over the legal limit	75 days
29 mph over the legal limit	80 days
30 mph over the legal limit	90 days
31 mph over the legal limit	100 days
32 mph over the legal limit	110 days
33 mph over the legal limit	120 days
34 mph over the legal limit	130 days
35 mph over the legal limit	140 days
36 mph over the legal limit	150 days
37 mph over the legal limit	160 days
38 mph over the legal limit	170 days
39 mph over the legal limit	180 days
40 mph over the legal limit	190 days
41 mph over the legal limit	210 days
42 mph over the legal limit	230 days
43 mph over the legal limit	250 days
44 mph over the legal limit	270 days
45 mph over the legal limit	290 days
46 mph over the legal limit	310 days
47 mph over the legal limit	330 days
48 mph over the legal limit	350 days
49 mph or more over the legal limit	one year

d. The person was convicted of violating Iowa Code section 321.372(3) or a similar ordinance of any political subdivision. The suspension period shall be:

- (1) 30 days for a first conviction unless otherwise provided in subparagraph 615.43(1) "a"(4).
- (2) 90 days for a second conviction.
- (3) 180 days for a third or subsequent conviction.

e. The person was convicted of violating Iowa Code section 321.323A or a similar ordinance of any political subdivision. The suspension period shall be:

- (1) 90 days for a violation causing property damage only to the property of another person.
- (2) 180 days for a violation causing bodily injury to another person.
- (3) One year for a violation causing death.

This rule is intended to implement Iowa Code sections 321.210, 321.323A, 321.372 and 321.491. [ARC 0250C, IAB 8/8/12, effective 9/12/12; ARC 0309C, IAB 9/5/12, effective 8/15/12; ARC 4119C, IAB 11/7/18, effective 12/12/18; ARC 4758C, IAB 11/6/19, effective 12/11/19; ARC 5017C, IAB 4/8/20, effective 5/13/20]

761—615.18(321) Suspension under the nonresident violator compact.

615.18(1) The department may suspend a person's license when a report is received from another state under the nonresident violator compact that an Iowa licensee has failed to comply with the terms of a traffic citation.

615.18(2) The suspension shall begin 30 days after the department's notice of suspension is served.

615.18(3) The suspension shall continue until the department issues a notice terminating the suspension. The department shall terminate the suspension when it receives evidence of compliance with the terms of the citation.

This rule is intended to implement Iowa Code sections 321.210 and 321.513.

761—615.19(321) Suspension for a charge of vehicular homicide. In accordance with Iowa Code section 321.210D, the department shall suspend a person's license when the department receives notice from the clerk of the district court that an indictment or information has been filed charging the person with homicide by vehicle under Iowa Code section 707.6A, subsection 1 or 2. The suspension shall begin ten days after the department's suspension notice is issued.

This rule is intended to implement Iowa Code section 321.210D.

761—615.20(321) Suspension for moving violation during driving probation. The department may suspend the license of a person convicted of a moving violation pursuant to Iowa Code section 321.210C. The suspension period shall be equal in duration to the original period of suspension, revocation or bar, or for one year, whichever is the shorter period.

This rule is intended to implement Iowa Code section 321.210C.
[ARC 4119C, IAB 11/7/18, effective 12/12/18]

761—615.21(321) Suspension of a minor's school license and minor's restricted license.

615.21(1) *Suspension of a minor's school license.*

a. The department may suspend a minor's school license upon receiving notice of the licensee's conviction for one moving violation or evidence of one or more accidents chargeable to the licensee.

b. The department may also suspend a minor's school license when the department receives written notice from a peace officer, parent, custodian or guardian, school superintendent, superintendent's designee or nonpublic school authority that the licensee has violated the restrictions of the license.

c. The suspension period under this subrule shall be at least 30 days.

615.21(2) *Suspension of a minor's restricted license.* The department may suspend a minor's restricted license upon receiving notice of the licensee's conviction for one moving violation. The suspension period shall be at least 30 days.

This rule is intended to implement Iowa Code sections 321.178 and 321.194.
[ARC 5496C, IAB 3/10/21, effective 4/14/21]

761—615.22(321) Suspension for nonpayment of fine, penalty, surcharge or court costs.

615.22(1) The department shall suspend a person's privilege to operate motor vehicles in Iowa when the department is notified by a clerk of the district court that the person has been convicted of violating a law regulating the operation of motor vehicles, that the person has failed to pay the fine, penalty, surcharge or court costs arising out of the conviction, and that 60 days have elapsed since the person was mailed a notice of nonpayment from the clerk of the district court.

a. The suspension period shall begin 30 days after the notice of suspension is served.

b. The suspension shall continue until the department has issued a notice terminating the suspension. The department shall terminate the suspension when it receives evidence that all appropriate payments have been made.

c. An informal settlement, hearing or appeal to contest the suspension shall be limited to a determination of whether the facts required by Iowa Code section 321.210A and this subrule are true. The merits of the conviction shall not be considered.

615.22(2) Reserved.

This rule is intended to implement Iowa Code section 321.210A.
[ARC 0592C, IAB 2/6/13, effective 3/13/13; ARC 4119C, IAB 11/7/18, effective 12/12/18]

761—615.23(321) Suspensions for juveniles.

615.23(1) *Suspension for juveniles adjudicated delinquent for certain offenses.*

a. Pursuant to Iowa Code section 321.213A, the department shall suspend the license of a person for one year upon receipt of an adjudication and dispositional order from the clerk of the juvenile court.

b. The department may issue to a person suspended under this subrule a temporary restricted license in accordance with rule 761—615.45(321) if issuance is permitted under Iowa Code section 321.215 and the person is otherwise eligible for the license. To obtain a temporary restricted license that is valid for educational purposes, the applicant must meet the requirements for issuance of a minor's school license under Iowa Code section 321.194 and rule 761—602.26(321).

615.23(2) Suspension for juvenile's failure to attend school.

a. The department shall suspend the driver's license of a person under the age of 18 upon receipt of notification from the appropriate school authority that the person does not attend school.

b. "School" means a public school, an accredited nonpublic school, competent private instruction in accordance with the provisions of Iowa Code chapter 299A, an alternative school or adult education classes.

c. "Appropriate school authority" means the superintendent of a public school or the chief administrator of an accredited nonpublic school, an alternative school or adult education.

d. The suspension shall continue until the person reaches the age of 18 or until the department receives notification from the appropriate school authority that the person is attending school.

e. The department may issue to the person a minor's restricted license in accordance with Iowa Code section 321.178 and rule 761—602.25(321) if the person is eligible for the license.

This rule is intended to implement Iowa Code sections 232.52(2), 299.1B, 321.213, 321.213A, 321.213B and 321.215.

[ARC 4119C, IAB 11/7/18, effective 12/12/18]

761—615.24(252J) Suspension upon receipt of a certificate of noncompliance.

615.24(1) From child support recovery unit.

a. The department shall suspend a person's Iowa-issued driver's license upon receipt of a certificate of noncompliance from the child support recovery unit.

b. The suspension shall begin 30 days after the department's notice of suspension is served.

c. The suspension shall continue until receipt of a withdrawal of the certificate of noncompliance from the child support recovery unit.

d. The filing of an application pursuant to Iowa Code section 252J.9 stays the suspension pending the outcome of the district court hearing.

615.24(2) From college student aid commission. Rescinded IAB 11/6/19, effective 12/11/19.

615.24(3) From department of revenue. Rescinded IAB 2/8/12, effective 3/14/12.

This rule is intended to implement Iowa Code sections 252J.1, 252J.8 and 252J.9.

[ARC 7902B, IAB 7/1/09, effective 8/5/09; ARC 9991B, IAB 2/8/12, effective 3/14/12; ARC 4758C, IAB 11/6/19, effective 12/11/19]

761—615.25(321) Suspension—driver's license indebtedness clearance pilot project. Rescinded IAB 11/8/06, effective 12/13/06.

761—615.26(321) Suspension for violation of a license restriction. The department may suspend a person's license when the department receives satisfactory evidence of a violation of a restriction imposed on the license. The suspension period shall be at least 30 days.

This rule is intended to implement Iowa Code section 321.193.

[ARC 5496C, IAB 3/10/21, effective 4/14/21]

761—615.27 and 615.28 Reserved.

761—615.29(321) Mandatory revocation.

615.29(1) The department shall revoke a person's license upon receipt of a record of the person's conviction for an offense listed under Iowa Code section 321.209.

615.29(2) The department shall revoke a person's license under Iowa Code subsection 321.209(2) upon receipt of a record of the person's conviction for a felony:

a. Which provides specific factual findings by the court that a motor vehicle was used in the commission of the offense,

b. Which is accompanied by information from the prosecuting attorney indicating that a motor vehicle was used in the commission of the crime, or

c. Where the elements of the offense actually required the use of a motor vehicle.

615.29(3) The revocation period shall be at least one year except:

a. The revocation period for two convictions of reckless driving shall be at least five days and not more than 30 days.

b. The revocation period for a first offense for drag racing shall be six months if the violation did not result in personal injury or property damage.

This rule is intended to implement Iowa Code sections 321.209, 321.212, 321.261 and 707.6A.

[ARC 4119C, IAB 11/7/18, effective 12/12/18; ARC 4758C, IAB 11/6/19, effective 12/11/19]

761—615.30(321) Revocation for out-of-state offense. The department may revoke an Iowa resident's license when the department is notified by another state that the person committed an offense in that state which, if committed in Iowa, would be grounds for revocation. The notice may indicate either a conviction or a final administrative decision. The period of the revocation shall be the same as if the offense had occurred in Iowa.

This rule is intended to implement Iowa Code section 321.205.

[ARC 4119C, IAB 11/7/18, effective 12/12/18]

761—615.31(321) Revocation for violation of a license restriction. Rescinded IAB 11/18/98, effective 12/23/98.

761—615.32(321) Extension of suspension or revocation period under Iowa Code chapter 321J. Anything in rule 761—615.11(321) notwithstanding, the department shall extend the period of license suspension or revocation for an additional like period when the person is convicted of operating a motor vehicle while the person's license is suspended or revoked under Iowa Code chapter 321J.

This rule is intended to implement Iowa Code section 321J.21.

[ARC 4119C, IAB 11/7/18, effective 12/12/18]

761—615.33(321) Revocation of a minor's license.

615.33(1) The department shall revoke a minor's restricted license upon receiving a record of the minor's conviction for two or more moving violations.

615.33(2) The department shall revoke a minor's school license upon receiving a record of the minor's conviction for two or more moving violations.

This rule is intended to implement Iowa Code subsection 321.178(2) and section 321.194.

761—615.34(321J) Other revocations. Rescinded IAB 11/18/98, effective 12/23/98.

761—615.35 Reserved.

761—615.36(321) Effective date of suspension, revocation, disqualification or bar. Unless otherwise specified by statute or rule, a suspension, revocation, disqualification or bar shall begin 30 days after the department's notice of suspension, revocation, disqualification or bar is served.

This rule is intended to implement Iowa Code sections 321.208, 321.209, 321.210, and 321.556.

761—615.37(321) Service of notice.

615.37(1) The department shall send a notice of denial, cancellation, suspension, revocation, disqualification or bar by first-class mail to the person's mailing address as shown on departmental records.

615.37(2) In lieu of service by mail, the notice may be delivered by a peace officer, a departmental employee, or any person over 18 years of age.

a. The person serving the notice shall prepare a certificate of personal service certifying delivery, specifying the name of the receiver, the address and the date, or certifying nondelivery.

b. The department shall pay fees for personal service of notice by a sheriff as specified in Iowa Code section 331.655. The department may also contract for personal service of notice when the department determines that it is in the best interests of the state.

615.37(3) The denial, cancellation, suspension, revocation, disqualification or bar shall become effective on the date specified in the notice.

615.37(4) The department may prepare an affidavit of mailing verifying the fact that a notice was mailed by first-class mail. To verify the mailing of a notice, the department may use its records in conjunction with U.S. Postal Service records available to the department. The department's affidavit of mailing may be attested to and certified in accordance with Iowa Code section 622.1.

This rule is intended to implement Iowa Code sections 321.16, 321.211, 321.211A, 321.556, 321J.9, 321J.12, and 331.655.

[ARC 3027C, IAB 4/12/17, effective 5/17/17]

761—615.38(17A,321) Hearing and appeal process.

615.38(1) Applicability. This rule applies to:

a. License denials, cancellations and suspensions under Iowa Code sections 321.177 to 321.215 and 321A.4 to 321A.11 except suspensions under Iowa Code sections 321.213A and 321.213B.

b. License suspensions and revocations under Iowa Code sections 321.218 and 321J.21.

c. License revocations under Iowa Code sections 321.193 and 321.205.

d. Disqualifications from operating a commercial motor vehicle under Iowa Code section 321.208.

e. License bars under Iowa Code section 321.556.

615.38(2) Submission of request or appeal.

a. A person subject to a sanction listed in subrule 615.38(1) may contest the action by following the provisions of 761—Chapter 13 as supplemented by this rule.

b. A request for an informal settlement, a request for a contested case hearing, or an appeal of a presiding officer's decision shall be submitted to the director of the driver and identification services bureau at the address in rule 761—615.3(17A).

c. The request or appeal shall include the person's name, date of birth, driver's license or permit number, complete address and telephone number, and the name, address and telephone number of the person's attorney, if any.

615.38(3) Informal settlement or hearing.

a. The person may request an informal settlement. Following an unsuccessful informal settlement procedure, or instead of that procedure, the person may request a contested case hearing.

b. Notwithstanding paragraph 615.38(3)“*a.*,” a request received from a person who has participated in a driver improvement interview on the same matter shall be deemed a request for a contested case hearing.

c. A request for an informal settlement or a request for a contested case hearing shall be deemed timely submitted if it is delivered to the director of the driver and identification services bureau or postmarked within the time period specified in the department's notice of the sanction.

(1) Unless a longer time period is specified in the notice or another time period is specified by statute or rule, the time period shall be 20 days after the notice is served.

(2) If the department fails to specify a time period in the notice, the request may be submitted at any time.

615.38(4) Appeal. An appeal of a presiding officer's decision shall be submitted in accordance with 761—13.7(17A).

615.38(5) Stay of sanction.

a. When the department receives a properly submitted, timely request for an informal settlement, request for a contested case hearing or appeal of a presiding officer's proposed decision regarding a sanction listed in subrule 615.38(1), it shall, after a review of its records to determine eligibility, stay

(stop) the sanction pending the outcome of the settlement, hearing or appeal unless prohibited by statute or rule or unless otherwise specified by the requester/appellant.

(1) If the stay is granted, the department shall issue and send to the person a notice granting the stay. The stay is effective on the date of issuance. The notice allows the person to drive while the sanction is stayed if the license is valid and no other sanction is in effect.

(2) A person whose stay authorizes driving privileges shall carry the notice of stay at all times while driving.

b. Of the sanctions listed in subrule 615.38(1), the department shall not stay the following, and the person's driving privileges do not continue:

(1) A suspension for incapability.

(2) A denial.

(3) A disqualification from operating a commercial motor vehicle.

(4) A suspension under Iowa Code section 321.180B.

(5) A suspension or revocation under Iowa Code section 321.218 or 321J.21.

This rule is intended to implement Iowa Code chapter 17A and sections 321.177 to 321.215, 321.218, 321.556, 321A.4 to 321A.11, and 321J.21.

[ARC 4119C, IAB 11/7/18, effective 12/12/18; ARC 5496C, IAB 3/10/21, effective 4/14/21]

761—615.39(321) Surrender of license. A person whose Iowa license has been canceled, suspended, revoked or barred or who has been disqualified from operating a commercial motor vehicle shall surrender the license to the designated representative of the department on or before the effective date of the sanction.

This rule is intended to implement Iowa Code sections 321.201, 321.208, 321.212, 321.216, 321.556, and 321A.31.

761—615.40(321) License reinstatement or reissue. The department may reinstate the license when the denial, cancellation, suspension, revocation, bar or disqualification has ended if the person has:

615.40(1) Filed proof of financial responsibility under Iowa Code chapter 321A, when required, for all vehicles to be operated. The class of license issued will depend on the examinations passed and other qualifications of the applicant. Regardless of the class of license issued, the license shall be valid only for the operation of the motor vehicles covered under the proof of financial responsibility filed by the applicant.

615.40(2) Paid the civil penalty when required by Iowa Code section 321J.17.

615.40(3) Complied with the specific instructions given in the department's notice terminating the sanction.

615.40(4) Successfully completed the required driver license examination.

615.40(5) Paid the reinstatement fee when required. The reinstatement fee is specified in Iowa Code section 321.191.

615.40(6) Paid the appropriate license fee or duplicate license fee. These fees are specified in Iowa Code sections 321.191 and 321.195.

This rule is intended to implement Iowa Code sections 321.186, 321.191, 321.195, 321.208, 321.212, 321A.17 and 321J.17.

[ARC 7902B, IAB 7/1/09, effective 8/5/09; ARC 4119C, IAB 11/7/18, effective 12/12/18; ARC 5496C, IAB 3/10/21, effective 4/14/21]

761—615.41(321) Investigation of convictions based on fraud. A person requesting investigation of fraudulent use of a person's name or other fraudulent identification that resulted in a record of conviction for a scheduled violation under Iowa Code chapter 321 and listed in Iowa Code section 805.8A may submit a written application to the department using Form 420049. The department shall review the application and may investigate, if appropriate, as required by Iowa Code section 321.200A. Form 420049 may be obtained by contacting the Bureau of Investigation and Identity Protection, Iowa

Department of Transportation, 6310 SE Convenience Blvd., Ankeny, Iowa; or on the department's website.

This rule is intended to implement Iowa Code section 321.200A.
[ARC 2424C, IAB 3/2/16, effective 4/6/16; ARC 4119C, IAB 11/7/18, effective 12/12/18]

761—615.42(321) Remedial driver improvement action under Iowa Code section 321.180B.

615.42(1) The department shall require remedial driver improvement action when a person holding an instruction permit, an intermediate license or a full-privilege driver's license under Iowa Code section 321.180B is convicted of a moving violation or has a contributive accident and the violation or accident occurred during the term of the instruction permit or intermediate license.

615.42(2) Completion of remedial driver improvement action means any or all of the following as determined by the department: suspension, safety advisory letter, additional restriction(s), vision screening, knowledge examination, and driving examination.

615.42(3) A suspension period under this rule shall be for no less than 30 days nor longer than one year. A person whose driving privilege has been suspended under this rule is not eligible for a temporary restricted license.

615.42(4) Remedial driver improvement action or suspension under this rule terminates when a person attains the age of 18.

This rule is intended to implement Iowa Code section 321.180B.
[ARC 7902B, IAB 7/1/09, effective 8/5/09]

761—615.43(321) Driver improvement program.

615.43(1) *When required.*

a. In lieu of suspension, the department may require the following persons to attend and successfully complete, at the person's own expense, a driver improvement program approved by the department:

- (1) A habitual violator.
- (2) A person who is convicted for speeding at least 25 but not more than 29 miles per hour over the legal limit.
- (3) A person whose license is subject to suspension under Iowa Code section 321.210C.
- (4) A person who is convicted of a first offense violation of Iowa Code section 321.372(3) or a similar ordinance of any political subdivision.

b. However, a person shall not be assigned to a driver improvement program more than once within a two-year period.

615.43(2) *Scheduling.* The department shall forward the person's contact information to the approved driver improvement program provider nearest the person's last known address. The provider will schedule the person's attendance at the provider's next available program opening.

a. One request for rescheduling may be granted by the provider if the program begins within 30 days of the originally scheduled date and if space is available.

b. A request to attend a program in another state may be granted if the curriculum is approved by the department.

615.43(3) *Probation.* When a person is required to attend and successfully complete a driver improvement program, the department shall also require the person to complete a probationary driving period not to exceed one year. One conviction for a moving violation committed during probation may result in suspension of the person's license. The suspension period shall be at least 90 days, unless reduced by a driver's license hearing officer based on mitigating circumstances.

615.43(4) *Failure to attend.* The department shall suspend the license of a person who is required to attend a driver improvement program and who does not attend, or does not successfully complete, the program. The suspension period shall be for the length of the original underlying suspension.

This rule is intended to implement Iowa Code sections 321.210 and 321.210C.
[ARC 5017C, IAB 4/8/20, effective 5/13/20; ARC 5496C, IAB 3/10/21, effective 4/14/21]

761—615.44(321) Driver improvement interview. Rescinded ARC 5496C, IAB 3/10/21, effective 4/14/21.

761—615.45(321) Temporary restricted license (work permit).

615.45(1) Ineligibility. The department shall not issue a temporary restricted license under Iowa Code section 321.215 to an applicant:

- a. Whose license has been denied or canceled.
- b. Whose license has been suspended for incapability.
- c. Whose license has been suspended for noncompliance with the financial responsibility law.
- d. Whose minor's school license or minor's restricted license has been suspended or revoked.
- e. Whose period of suspension or revocation has been extended for operating a motor vehicle while under suspension or revocation unless the underlying suspension or revocation qualifies for issuance of a temporary restricted license.
- f. Whose license has been mandatorily revoked under Iowa Code section 321.209, subsections 1 to 4 or subsection 7, or for a second or subsequent conviction for drag racing.
- g. Whose license is barred under Iowa Code section 321.560 unless the applicant is declared to be a habitual offender under Iowa Code section 321.555(1) "c" or 321.555(2).
- h. Whose license has been suspended due to receipt of a certificate of noncompliance from the child support recovery unit.
- i. Whose license has been suspended for a charge of vehicular homicide.
- j. Whose license has been suspended under Iowa Code section 321.180B(3).

615.45(2) Application.

a. To obtain a temporary restricted license, an applicant shall complete and submit Form 430100 and any supporting documentation to the driver and identification services bureau at the address in rule 761—615.3(17A).

b. A temporary restricted license issued for employment may include permission for the licensee to transport dependent children to and from a location for child care when that activity is essential to continuation of the licensee's employment.

615.45(3) Statements. A person applying for a temporary restricted license shall submit all of the following statements that apply to the person's situation. Each statement shall explain the need for the license and shall list specific places and times for the activity which can be verified by the department.

- a. A statement from the applicant.
- b. A statement from the applicant's employer unless the applicant is self-employed including, when applicable, verification that the applicant's use of a child care facility is essential to the applicant's continued employment.
- c. A statement from the health care provider if the applicant or the applicant's dependent requires continuing health care.
- d. A statement from the educational institution in which the applicant is enrolled.
- e. A statement from the substance abuse treatment program in which the applicant is participating.
- f. A copy of the court order for community service and a statement describing the assigned community service from the responsible supervisor.
- g. A statement from the child care provider.

615.45(4) Additional requirements. An applicant for a temporary restricted license shall also:

- a. Provide a description of all motor vehicles to be operated under the temporary restricted license.
- b. File proof of financial responsibility under Iowa Code chapter 321A, if required, for all motor vehicles to be operated under the temporary restricted license.
- c. Pay the civil penalty when required by Iowa Code section 321J.17.

615.45(5) Issuance and restrictions.

a. When the application is approved and all requirements are met, the applicant shall be notified by the department. The applicant shall pass the appropriate examination for the type of vehicle to be operated under the temporary restricted license. An Iowa resident shall also pay the reinstatement and license fees.

b. The department shall determine the restrictions to be imposed by the temporary restricted license. The licensee shall apply to the department in writing with a justification for any requested change in license restrictions.

615.45(6) Denial. An applicant who has been denied a temporary restricted license or who contests the license restrictions imposed by the department may contest the decision in accordance with rule 761—615.38(321).

This rule is intended to implement Iowa Code chapter 321A and sections 252J.8, 321.177, 321.178, 321.184, 321.185, 321.186, 321.189, 321.191, 321.193, 321.194, 321.201, 321.205, 321.209, 321.210, 321.210A, 321.212, 321.213A, 321.213B, 321.215, 321.218, 321.513, 321.560 and 321J.17.

[ARC 4119C, IAB 11/7/18, effective 12/12/18; ARC 4758C, IAB 11/6/19, effective 12/11/19; ARC 5496C, IAB 3/10/21, effective 4/14/21]

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[Filed ARC 5496C (Notice ARC 5385C, IAB 1/13/21), IAB 3/10/21, effective 4/14/21]

[◇] Two or more ARCs

CHAPTER 920
STATE TRANSIT ASSISTANCE
[Prior to 6/3/87, Transportation Department [820]—(09,B)Ch 1]

761—920.1(324A) Statement of policy. State financial assistance to any public transit system shall be restricted to joint projects with the department that hold substantial promise of accomplishing the following goals:

920.1(1) Development, maintenance and improvement of transit services for the general public and for transportation disadvantaged persons.

920.1(2) Protection of the rights of private enterprise public transit providers, especially those providing intercity scheduled services on fixed routes.

920.1(3) Improvement of transit system effectiveness and efficiency.
[ARC 3194C, IAB 7/5/17, effective 8/9/17]

761—920.2(324A) General information. The department shall post annually the required forms and instructions for applying for state transit assistance to the department's website at www.iowadot.gov and notify each public transit system in Iowa of the availability. Requests for assistance and questions about application preparation should be directed to: Public Transit Bureau, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; telephone (515)233-7870.

[Editorial change: IAC Supplement 2/23/11; ARC 3194C, IAB 7/5/17, effective 8/9/17; ARC 5497C, IAB 3/10/21, effective 4/14/21]

761—920.3(324A) Definitions. The definitions in Iowa Code section 324A.1, except for the definition of "urban transit system," apply to this chapter. In addition:

"*Formula assistance*" means state transit assistance appropriations minus funds reserved for special projects.

"*Joint participation agreement*" means a contract between the department and a public transit system for either operations or capital assistance needed for implementation of a transit service project or projects. Each agreement shall include, but not be limited to, a project budget, method of payment, and period of performance.

"*Project*" means a concerted set of actions that will develop, maintain, or improve one or more elements of the public transit system's service.

"*Urban transit system*" means a system designated by the department which meets the requirements of Iowa Code section 324A.1(8). To be designated as an urban transit system for the purposes of this chapter, the system must serve a city or urbanized area with a population of 20,000 or more. The system also must be managed by a board of local officials who have either been elected by the public or appointed by elected officials, and who are responsible for policy and oversight of transit services for one or more incorporated areas within Iowa.

[ARC 3194C, IAB 7/5/17, effective 8/9/17; ARC 5497C, IAB 3/10/21, effective 4/14/21]

761—920.4(324A) Types of projects.

920.4(1) *Formula projects.* A formula project may involve operations assistance, capital assistance, planning, or any combination of the three. These projects are developed, analyzed and ranked through the transit planning process which involves the following steps:

a. Each public transit system shall arrange with the appropriate planning agencies for a review of all projects submitted, shall ensure public participation and discussion, and shall list the projects by priority.

b. Each public transit system shall submit its ranked list of proposed projects to the department.

920.4(2) *Special projects.*

a. Special projects are extraordinary, emergency or innovative in nature, and may include, but are not limited to, the following purposes:

(1) Expanding the scope of planning, managerial, or technical expertise.

(2) Increasing the public's awareness and understanding of transit.

(3) Enhancing the capacity for administration consolidation and service coordination.

- (4) Reducing impediments to intramodal or intermodal transfers.
- (5) Increasing the cooperation and coordination between private and public sectors.
- (6) Developing, demonstrating, or refining a technical, procedural, or mechanical innovation that may be utilized by other public transit systems in Iowa.
- (7) Responding to an emergency situation that places an extraordinary and unforeseen strain on the resources of a public transit system.

b. Applications for training fellowships may be submitted to the department at any time.

c. Applications for special projects are due to the department by October 1 each year. The department may announce to the public transit systems the acceptance of special project applications at other times of the year if unobligated funds are available.

[ARC 3194C, IAB 7/5/17, effective 8/9/17; ARC 5497C, IAB 3/10/21, effective 4/14/21]

761—920.5(324A) Standards for projects.

920.5(1) Requirements for transit system. A public transit system is eligible for project assistance if the system is in compliance with all of the following criteria:

- a.* The transit system abides by all applicable state and federal laws and regulations.
- b.* The transit system maintains primary documentation for all revenues and expenses for a period of at least three years.
- c.* The transit system maintains the system's policies, routes, schedules, fare structure, and budget in a manner that encourages public review, responsiveness to user concerns, energy conservation, and fiscal solvency.
- d.* The transit system received departmental approval of the system's plan or schedule for repayment of any loan administered by the department.
- e.* The transit system accurately reports all services to be supported with project formula assistance and ensures that all services are open to the general public.

920.5(2) Project conditions. The department shall obligate state transit assistance for joint projects that meet the following criteria:

- a.* Each project must be included in the current year of the locally adopted transportation improvement program.
- b.* Each project shall contain payment criteria, through the joint participation agreement, which are mutually agreed upon by the department and the contracting officer of the transit system.
- c.* Each special project shall have a preestablished basis for determining success using a specified means of performance management and shall have a detailed budget of the resources available and the assistance necessary for implementation.
- d.* State assistance for a special project involving capital expense shall not exceed 85 percent of the project's total capital expense. State assistance for a special project involving operating support shall not exceed 80 percent of the project's total operating expense in the first year and 50 percent of the project's total operating expense in the second year.

920.5(3) Items not eligible for assistance.

- a.* Administrative, operations, or capital expenses which are determined by the department to be inconsistent with department policies, public law, officially approved planning and programming documents, or inconsistent with the purpose of improving the effectiveness and quality of transit services.
- b.* Development of managerial, administrative, or operational systems which duplicate programs made available at no charge to the transit system by the department.

920.5(4) Determination of system eligibility for formula assistance.

a. Prior to the beginning of each fiscal year, each state-designated public transit system's formula percentage shall be determined through the process shown in the appendix located at the end of this chapter.

(1) Transit system data used in determining formula percentage is based only on services which are open to the general public and is derived from the last fiscal year for which complete information is available.

(2) The process shown in the appendix establishes the percentage of available state transit assistance funds not reserved for special projects for which each transit system is eligible during the fiscal year.

b. The amount of each system's eligibility for formula assistance from this appropriation shall be determined by multiplying the system's formula percentage by the amount of the appropriation not reserved for special projects.

c. If the dollar amount of state transit assistance is not known until the funds are actually deposited in the state transit assistance account, the amount of each system's eligibility for formula assistance from these funds shall be determined as follows: At the beginning of each month, the system's formula percentage shall be multiplied by the amount of new funds not reserved for special projects that were deposited in the state transit assistance account during the previous month.

d. A transit system's eligibility for programmed project assistance may be reduced if it is subject to the sanctions outlined in Iowa Code section 324A.5 or 761—Chapter 910.

920.5(5) *Determination of amount reserved for special projects.* Each fiscal year, at least \$300,000 will be reserved from state transit assistance appropriations for special projects. Any special project funds not obligated in the previous fiscal year and any funds made available through closeout of previously approved projects may also be reserved for special projects. Special project funds are distributed by the department on a discretionary basis in accordance with subrule 920.4(2).
[ARC 3194C, IAB 7/5/17, effective 8/9/17]

761—920.6(324A) Processing.

920.6(1) *Review.* The department shall review the proposed projects.

920.6(2) *Program.* Based on available funds and the project priorities established by the transit systems, the department shall prepare a set of funding recommendations.

920.6(3) *Approval and agreement.* Upon approval of the projects by the transportation commission, the department shall prepare a joint participation agreement and send it to each public transit system for execution.

920.6(4) *Advance payment allowed.* Each transit system with a signed joint participation agreement may be paid formula assistance monthly, in advance of project expenditures, if all of the following conditions are met:

a. The transit system included in its application a request for advance allocations as set forth in Iowa Code section 324A.6.

b. The transit system is current on all reporting required by the department.

c. The transit system is current on all scheduled repayments under loan contracts from the department.

[ARC 3194C, IAB 7/5/17, effective 8/9/17]

These rules are intended to implement Iowa Code chapter 324A.

APPENDIX TO
761—920.5(324A)

FP	Formula percentage. The percentage of any state transit assistance appropriation that a public transit system is eligible to receive from the nondiscretionary portion of the appropriation. Determination of a public transit system's formula percentage shall be made using the method diagrammed in this appendix.
FY	Fiscal year. The 12-month period beginning July 1 of one year and ending June 30 of the following year.
LDI	Locally determined income. All transit system revenue dedicated for operations expense during a fiscal year, minus federal operating assistance from the U.S. Department of Transportation and minus all special project operating support and formula assistance funds received from the Iowa Department of Transportation.
OpExp	Operations expense. All eligible transit system expenses related to operating, maintaining, and administering transit operations.
Pass	Passenger. A person boarding a transit vehicle for the purpose of making a trip. A passenger is counted each time that person boards a vehicle for travel to a destination.
RevMi	Revenue miles. Total vehicle miles traveled by revenue vehicles of public transit systems while in revenue service. Excludes miles traveled to and from storage facilities and other deadhead travel.

APPENDIX TO
761—920.5(324A)

FORMULA FOR DETERMINATION OF FORMULA PERCENTAGE

$$\begin{array}{l}
 \text{Regional} \\
 \text{System's} \\
 \text{FP} \\
 \\
 \text{Urban} \\
 \text{System's} \\
 \text{FP}
 \end{array}
 =
 \begin{array}{l}
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 .25 \\
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 .25 \\
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 .25 \\
 \\
 .25
 \end{array}
 \frac{\text{Regional RevMi}}{\text{Total State RevMi}} \times \frac{\text{System's LDI}}{\text{Sum of LDI for all regions}} +
 \frac{\text{Regional RevMi}}{\text{Total State RevMi}} \times \frac{\text{System's Pass to OpExp ratio}}{\text{Sum of Pass to OpExp ratios for all regions}} +
 \frac{\text{Regional RevMi}}{\text{Total State RevMi}} \times \frac{\text{System's RevMi to OpExp ratio}}{\text{Sum of RevMi to OpExp ratios for all regions}} +
 \frac{\text{Urban RevMi}}{\text{Total State RevMi}} \times \frac{\text{System's LDI}}{\text{Sum of LDI for all urbans}} +
 \frac{\text{Urban RevMi}}{\text{Total State RevMi}} \times \frac{\text{System Pass to OpExp ratio}}{\text{Sum of Pass to OpExp ratios for all urbans}} +
 \frac{\text{Urban RevMi}}{\text{Total State RevMi}} \times \frac{\text{System's RevMi to OpExp ratio}}{\text{Sum of RevMi to OpExp ratios for all urbans}}$$

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[Filed 2/18/82, Notice 1/6/82—published 3/17/82, effective 4/21/82]

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[Filed emergency 12/11/85—published 1/1/86, effective 1/1/86]

[Filed 2/20/86, Notice 1/1/86—published 3/12/86, effective 4/16/86]

[Filed 5/11/87, Notice 3/11/87—published 6/3/87, effective 7/8/87]

[Filed emergency 6/15/89 after Notice 5/3/89—published 7/12/89, effective 7/1/89]

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[Filed 3/25/94, Notice 2/16/94—published 4/13/94, effective 5/18/94]

[Filed 9/8/94, Notice 7/20/94—published 9/28/94, effective 11/2/94]

[Editorial change: IAC Supplement 2/23/11]

[Filed ARC 3194C (Notice ARC 3034C, IAB 4/26/17), IAB 7/5/17, effective 8/9/17]

[Filed ARC 5497C (Notice ARC 5312C, IAB 12/16/20), IAB 3/10/21, effective 4/14/21]

CHAPTER 923
CAPITAL MATCH REVOLVING LOAN FUND
[Prior to 6/3/87, Transportation Department[820]—(09.B)Ch 4]

761—923.1(71GA,ch265) General information.

923.1(1) Scope of chapter. The general assembly appropriated money from the petroleum overcharge fund to the department to be used as a revolving loan fund for transit capital purchases by public transit systems. The revolving loan fund will enable public transit systems to obtain the matching funds required to qualify for capital purchases under state or federally funded projects. The fund will provide multiyear interest-free loans to public transit systems to allow faster capital acquisitions. Loan recipients shall be required to demonstrate ability to repay the loan from budgeted funds or revenues.

923.1(2) Information. Requests for information about and for assistance with the preparation and submission of loan requests should be directed to the Public Transit Bureau, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; telephone (515)233-7870. Information is also available on the department's website at www.iowadot.gov.

[Editorial change: IAC Supplement 2/23/11; ARC 3693C, IAB 3/14/18, effective 4/18/18; ARC 5498C, IAB 3/10/21, effective 4/14/21]

761—923.2(71GA,ch265) Definitions.

“Department” means the Iowa department of transportation.

“Project” means a concerted set of actions that will develop, maintain or improve one or more elements of the public transit system's service.

“Public transit system” means the same as defined in Iowa Code section 324A.1.

[ARC 3693C, IAB 3/14/18, effective 4/18/18]

761—923.3(71GA,ch265) System eligibility. A public transit system is eligible to request a capital assistance loan from the revolving loan fund provided that the public transit system complies with all of the following criteria:

923.3(1) The transit system abides by all applicable state and federal laws and regulations.

923.3(2) The transit system maintains primary documentation for all revenues and expenses for a period of at least three years following contract closeout.

923.3(3) The transit system maintains the system's policies, routes, schedules, fare structure, and budget in a manner that encourages public review, responsiveness to user concerns, energy conservation, and fiscal solvency.

[ARC 3693C, IAB 3/14/18, effective 4/18/18; ARC 5498C, IAB 3/10/21, effective 4/14/21]

761—923.4(71GA,ch265) Project eligibility.

923.4(1) A project is eligible if it meets all of the following criteria:

a. The project is a transit-related project for a capital purchase, e.g., new or replacement vehicles, facilities, or both.

b. The project meets an identifiable transit need that has been included in the public transit system's adopted transportation improvement program.

c. The local funding needed for the project justifiably exceeds the public transit system's annual capital match funding capability.

923.4(2) A project to purchase vans for a vanpool, as defined in Iowa Code section 325A.12, may be submitted by an individual or a group through the appropriate public transit system. A vanpool project is eligible for an interest-free loan from the revolving loan fund only after funds for all other projects have been allocated.

[ARC 3693C, IAB 3/14/18, effective 4/18/18; ARC 5498C, IAB 3/10/21, effective 4/14/21]

761—923.5(71GA,ch265) Procedure.

923.5(1) Funding request. The public transit system shall submit a funding application for the proposed project to either the department or to the Federal Transit Administration, as required by the type of funding requested.

923.5(2) *Loan request.* The public transit system shall normally submit a request for a revolving fund loan to the department when the annual grant application is made, but may submit a request at any time if a specific need arises. The request shall include, but not be limited to, the following topics and documents:

- a. A description and cost estimate of the proposed project.
- b. An explanation of the benefits, including projected energy conservation benefits, to be gained from the project.
- c. An explanation and justification of need for the loan.
- d. A proposed schedule of when funds will be needed for the project.
- e. A proposed loan repayment plan with schedule and source of funds.

923.5(3) *Criteria for selection.* The department shall review each loan request and shall evaluate the projects for funding. Based on the following criteria (in no particular order), preference shall be given to projects that:

- a. Foster coordination among transit services, such as a ground transportation center, a joint maintenance facility, or cooperative vehicle usage.
- b. Enhance local or regional economic development, such as a transit mall, passenger shelter facilities, or vehicles for extension of services.
- c. Increase federal funding to the state, such as accelerating purchase of replacement vehicles.
- d. Extend services to the transportation disadvantaged.
- e. Promote energy conservation, such as fuel efficiency.
- f. Require the loan as only a portion of the local matching funds required.

923.5(4) *Approval.* Based on available funds, the department shall approve loans for projects meeting the criteria in rule 761—923.4(71GA,ch265).

923.5(5) *Agreement.* Upon approval, the department shall prepare a loan contract and send it to the public transit system for execution.

923.5(6) *Default.* If a public transit system fails to make a loan payment as agreed in the contract, the department may, at its option, deduct the amount of any past due loan payment from state transit assistance payments allocated to that transit system.

[ARC 3693C, IAB 3/14/18, effective 4/18/18]

These rules are intended to implement 1985 Iowa Acts, chapter 265.

[Filed emergency 4/2/86—published 4/23/86, effective 4/4/86]

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CHAPTER 924
PUBLIC TRANSIT INFRASTRUCTURE GRANT PROGRAM

761—924.1(324A) Purpose. The purpose of the public transit infrastructure grant program is to provide funding for improvement of the vertical infrastructure of Iowa’s designated public transit systems.

761—924.2(324A) Definitions. The following definitions shall apply to this chapter:

“*Public transit system*” means the same as defined in Iowa Code section 324A.1.

“*Vertical infrastructure*” means the same as defined in Iowa Code section 8.57(5).

[ARC 3194C, IAB 7/5/17, effective 8/9/17; ARC 5498C, IAB 3/10/21, effective 4/14/21]

761—924.3(324A) Information and forms. Information, instructions, and application forms are available from the Public Transit Bureau, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; telephone (515)233-7870; or the department’s website at www.iowadot.gov.
[ARC 3194C, IAB 7/5/17, effective 8/9/17; ARC 5498C, IAB 3/10/21, effective 4/14/21]

761—924.4 Reserved.

761—924.5(324A) Applicant eligibility. Rescinded ARC 3194C, IAB 7/5/17, effective 8/9/17.

761—924.6(324A) Project eligibility. Projects may be considered for funding only if:

924.6(1) The project has been included in a locally approved transportation improvement program and in the statewide transportation improvement program.

924.6(2) Local match for the project is currently available.

924.6(3) The project is capable of being substantially completed within 18 months of project selection.

761—924.7(324A) Eligible project activities. Activities that are eligible for reimbursement include, but are not limited to, the following:

924.7(1) Construction, expansion, or renovation of facilities for administration of public transit operations, including any associated design, land acquisition, grading and foundation work.

924.7(2) Construction, expansion, or renovation of facilities for servicing, maintenance or storage of public transit vehicles, including any associated design, land acquisition, grading and foundation work.

924.7(3) Construction, expansion, or renovation of transit vehicle fueling facilities, including any associated design, land acquisition, grading and foundation work.

924.7(4) Construction, expansion, or renovation of passenger waiting facilities, including any associated design, land acquisition, grading and foundation work.

924.7(5) Relocating an existing administrative or maintenance facility, if necessary to correct violations of safety or design standards. Such project may include any associated design, land acquisition, grading and foundation work.

761—924.8(324A) Ineligible project activities. A transit facility may be incorporated into a larger project. Examples might include, but are not limited to, an intermodal facility, a headquarters for the umbrella organization sponsoring the transit program, or a public works facility. If this is the case, those costs attributable to the nontransit elements of the larger project shall not be eligible under this program.

761—924.9 Reserved.

761—924.10(324A) Funding.

924.10(1) Program funds may reimburse up to 80 percent of transit-related project costs.

924.10(2) At least 20 percent of transit-related project costs must be provided from local sources by the sponsoring transit system in cash or value of real property.

924.10(3) Assistance from the public transit infrastructure grant program, when combined with federal or other state resources, may not exceed 80 percent of the project’s transit-related costs.

924.10(4) No single public transit system may receive more than 40 percent of the funding available in one year.

[ARC 5498C, IAB 3/10/21, effective 4/14/21]

761—924.11(324A) Project applications.

924.11(1) Project applications shall be submitted to the department.

924.11(2) Each application shall contain:

a. General information, including the transit system name, contact person, mailing address, email address, telephone number, and fax number.

b. A project data sheet. The data sheet shall include the following:

(1) A brief description of the project and its purpose, project justification and anticipated benefits to the transit program.

(2) Cost information including total project cost and an itemized breakdown of project components (including transit vs. nontransit costs).

(3) The proposed implementation schedule.

(4) A statement of the applicant's ability to complete the project.

(5) A sketch of the project.

c. Documentation of project justification.

d. A resolution from the governing body of the sponsoring transit system endorsing the project and authorizing the necessary local funding match.

[ARC 3194C, IAB 7/5/17, effective 8/9/17]

761—924.12 and 924.13 Reserved.

761—924.14(324A) Project priorities. The transportation commission shall consider the following in project selection:

924.14(1) Benefits of project to the transit program in terms of:

a. Enhancement of the life of the transit vehicle fleet.

b. Enhancement to transit services.

c. Increased ridership.

924.14(2) Readiness to proceed.

924.14(3) Feasibility of timely completion of the proposed project.

924.14(4) Ability of the project to leverage other funds.

761—924.15(324A) Review and approval. Department staff shall review project applications and shall submit recommendations to the transportation commission. The transportation commission is responsible for approving the projects to be funded.

[ARC 3194C, IAB 7/5/17, effective 8/9/17]

761—924.16(324A) Project agreement, administration and ownership.

924.16(1) Agreement. After a project has been approved, the department shall enter into an agreement with the transit system sponsoring the project.

924.16(2) Payments. Payments to the transit system sponsor for eligible project costs shall be made on a cost reimbursement basis.

924.16(3) Ownership. The transit system must retain ownership of the new, renovated or repaired structure or facility for its useful life. If the structure or facility is transferred to a subcontracted entity or is sold before the useful life has expired, the transit system must repay the prorated state interest to the department. Useful life thresholds can be found in the department's transit manager's handbook, available on the department's website at www.iowadot.gov.

[ARC 3194C, IAB 7/5/17, effective 8/9/17; ARC 5498C, IAB 3/10/21, effective 4/14/21]

These rules are intended to implement Iowa Code sections 8.57, 324A.1 and 324A.6A.

[Filed 12/13/06, Notice 11/8/06—published 1/3/07, effective 2/7/07]

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[Filed ARC 5498C (Notice ARC 5313C, IAB 12/16/20), IAB 3/10/21, effective 4/14/21]

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[Prior to 11/19/97, see Labor Services Division[347]]

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CHAPTER 10
GENERAL INDUSTRY SAFETY AND HEALTH RULES

[Prior to 9/24/86, Labor, Bureau of [530]]

[Prior to 10/7/98, see 347—Ch 10]

875—10.1(88) Definitions. As used in these rules, unless the context clearly requires otherwise:

“*Part*” means 875—Chapter 10, Iowa Administrative Code.

“*Standard*” means a standard which requires conditions, or the adoption or use of one or more practices, means, methods, operations, or processes, reasonably necessary or appropriate to provide safe or healthful employment and places of employment.

875—10.2(88) Applicability of standards.

10.2(1) None of the standards in this chapter shall apply to working conditions of employees with respect to which federal agencies other than the United States Department of Labor, exercise statutory authority to prescribe or enforce standards or regulations affecting occupational safety or health.

10.2(2) If a particular standard is specifically applicable to a condition, practice, means, method, operation, or process, it shall prevail over any different general standard which might otherwise be applicable to the same condition, practice, means, method, operation, or process.

10.2(3) However, any standard shall apply according to its terms to any employment and place of employment in any industry, even though particular standards are also prescribed for the industry, as in 1910.12, 1910.261, 1910.262, 1910.263, 1910.264, 1910.265, 1910.266, 1910.267, and 1910.268 of 29 CFR 1910, to the extent that none of such particular standards applies.

10.2(4) In the event a standard protects on its face a class of persons larger than employees, the standard shall be applicable under this part only to employees and their employment and places of employment.

10.2(5) An employer who is in compliance with any standard in this part shall be deemed to be in compliance with the requirement of Iowa Code section 88.4, but only to the extent of the condition, practice, means, method, operation or process covered by the standard.

875—10.3(88) Incorporation by reference. The standards of agencies of the U.S. Government, and organizations which are not agencies of the U.S. Government which are incorporated by reference in this chapter have the same force and effect as other standards in this chapter. Only mandatory provisions (i.e., provisions containing the word “shall” or other mandatory language) of standards incorporated by reference are adopted under the Act.

875—10.4(88) Exception for hexavalent chromium exposure in metal and surface finishing job shops. Rescinded ARC 5490C, IAB 3/10/21, effective 4/14/21.

875—10.5 and 10.6 Reserved.

875—10.7(88) Definitions and requirements for a nationally recognized testing laboratory. The federal regulations adopted at 29 CFR, Chapter XVII, Part 1910, regulation 1910.7 and Appendix A, as published at 53 Fed. Reg. 12120 (April 12, 1988) and amended at 53 Fed. Reg. 16838 (May 11, 1988), 54 Fed. Reg. 24333 (June 7, 1989) and 65 Fed. Reg. 46818 (July 31, 2000) are adopted by reference.

875—10.8 to 10.11 Reserved.

875—10.12(88) Construction work.

10.12(1) Standards. The standards prescribed in 875—Chapter 26 are adopted as occupational safety and health standards and shall apply, according to the provisions thereof, to every employment and place of employment of every employee engaged in construction work. Each employer shall protect the employment and places of employment of each employee engaged in construction work by complying with the provisions of 875—Chapter 26.

10.12(2) Definition. For the purpose of this rule, “*construction work*” means work for construction, alteration, or repair including painting and redecorating, and where applicable, the erection of new electrical transmission and distribution lines and equipment, and the alteration, conversion, and improvement of the existing transmission and distribution lines and equipment. This incorporation by reference of 875—Chapter 26 (Part 1926) is not intended to include references to interpretative rules having relevance to the application of the construction safety Act, but having no relevance to the application of Iowa Code chapter 88.

875—10.13 to 10.18 Reserved.

875—10.19(88) Special provisions for air contaminants.

10.19(1) Asbestos, tremolite, anthophyllite, and actinolite dust. Reserved.

10.19(2) Vinyl chloride. Rule 1910.1017 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to vinyl chloride in every employment and place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to vinyl chloride which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(3) Acrylonitrile. Rule 1910.1045 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to acrylonitrile in every employment and place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to acrylonitrile which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(4) Inorganic arsenic. Rule 1910.1018 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to inorganic arsenic in every employment and place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to inorganic arsenic which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(5) Rescinded, effective 6/10/87.

10.19(6) Lead. Rescinded IAB 8/5/92, effective 8/5/92.

10.19(7) Ethylene oxide. Rule 1910.1047 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to ethylene oxide in every employment and place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to ethylene oxide which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(8) Benzene. Rule 1910.1028 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to benzene in every place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to benzene which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(9) Formaldehyde. Rule 1910.1048 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to formaldehyde in every place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to formaldehyde which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(10) Methylene chloride. Rule 1910.1052 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to methylene chloride in every employment and place of employment covered by 875—10.12(88) in lieu of any different standard on exposure to methylene chloride which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

875—10.20(88) Adoption by reference. The rules beginning at 1910.20 and continuing through 1910, as adopted by the United States Secretary of Labor shall be the rules for implementing Iowa Code chapter 88. This rule adopts the Federal Occupational Safety and Health Standards of 29 CFR, Chapter XVII, Part 1910 as published at 37 Fed. Reg. 22102 to 22324 (October 18, 1972) and as amended at:

37 Fed. Reg. 23719 (November 8, 1972)

37 Fed. Reg. 24749 (November 21, 1972)

38 Fed. Reg. 3599 (February 8, 1973)

38 Fed. Reg. 9079 (April 10, 1973)
38 Fed. Reg. 10932 (May 3, 1973)
38 Fed. Reg. 14373 (June 1, 1973)
38 Fed. Reg. 16223 (June 21, 1973)
38 Fed. Reg. 19030 (July 17, 1973)
38 Fed. Reg. 27048 (September 28, 1973)
38 Fed. Reg. 28035 (October 11, 1973)
38 Fed. Reg. 33397 (December 4, 1973)
39 Fed. Reg. 1437 (January 9, 1974)
39 Fed. Reg. 3760 (January 29, 1974)
39 Fed. Reg. 6110 (February 19, 1974)
39 Fed. Reg. 9958 (March 15, 1974)
39 Fed. Reg. 19468 (June 3, 1974)
39 Fed. Reg. 35896 (October 4, 1974)
39 Fed. Reg. 41846 (December 3, 1974)
39 Fed. Reg. 41848 (December 3, 1974)
40 Fed. Reg. 3982 (January 27, 1975)
40 Fed. Reg. 13439 (March 26, 1975)
40 Fed. Reg. 18446 (April 28, 1975)
40 Fed. Reg. 23072 (May 28, 1975)
40 Fed. Reg. 23743 (June 2, 1975)
40 Fed. Reg. 24522 (June 9, 1975)
40 Fed. Reg. 27369 (June 27, 1975)
40 Fed. Reg. 31598 (July 28, 1975)
41 Fed. Reg. 11504 (March 19, 1976)
41 Fed. Reg. 13352 (March 30, 1976)
41 Fed. Reg. 35184 (August 20, 1976)
41 Fed. Reg. 46784 (October 22, 1976)
41 Fed. Reg. 55703 (December 21, 1976)
42 Fed. Reg. 2956 (January 14, 1977)
42 Fed. Reg. 3304 (January 18, 1977)
42 Fed. Reg. 45544 (September 9, 1977)
42 Fed. Reg. 46540 (September 16, 1977)
42 Fed. Reg. 37668 (July 22, 1977)
43 Fed. Reg. 11527 (March 17, 1978)
43 Fed. Reg. 19624 (May 5, 1978)
43 Fed. Reg. 27394 (June 23, 1978)
43 Fed. Reg. 27434 (June 23, 1978)
43 Fed. Reg. 28472 (June 30, 1978)
43 Fed. Reg. 28473 (June 30, 1978)
43 Fed. Reg. 31330 (July 21, 1978)
43 Fed. Reg. 35032 (August 8, 1978)
43 Fed. Reg. 45809 (October 3, 1978)
43 Fed. Reg. 49744 (October 24, 1978)
43 Fed. Reg. 51759 (November 7, 1978)
43 Fed. Reg. 53007 (November 14, 1978)
43 Fed. Reg. 56893 (December 5, 1978)
43 Fed. Reg. 57602 (December 8, 1978)
44 Fed. Reg. 5447 (January 26, 1979)
44 Fed. Reg. 50338 (August 28, 1979)
44 Fed. Reg. 60981 (October 23, 1979)
44 Fed. Reg. 68827 (November 30, 1979)

45 Fed. Reg. 6713 (January 29, 1980)
45 Fed. Reg. 8594 (February 8, 1980)
45 Fed. Reg. 12417 (February 26, 1980)
45 Fed. Reg. 35277 (May 23, 1980)
45 Fed. Reg. 41634 (June 20, 1980)
45 Fed. Reg. 54333 (August 15, 1980)
45 Fed. Reg. 60703 (September 12, 1980)
46 Fed. Reg. 4056 (January 16, 1981)
46 Fed. Reg. 6288 (January 21, 1981)
46 Fed. Reg. 24557 (May 1, 1981)
46 Fed. Reg. 32022 (June 19, 1981)
46 Fed. Reg. 40185 (August 7, 1981)
46 Fed. Reg. 2632 (August 21, 1981)
46 Fed. Reg. 42632 (August 21, 1981)
46 Fed. Reg. 45333 (September 11, 1981)
46 Fed. Reg. 60775 (December 11, 1981)
47 Fed. Reg. 39161 (September 7, 1982)
47 Fed. Reg. 51117 (November 12, 1982)
47 Fed. Reg. 53365 (November 26, 1982)
48 Fed. Reg. 2768 (January 21, 1983)
48 Fed. Reg. 9641 (March 8, 1983)
48 Fed. Reg. 9776 (March 8, 1983)
48 Fed. Reg. 29687 (June 28, 1983)
49 Fed. Reg. 881 (January 6, 1984)
49 Fed. Reg. 4350 (February 3, 1984)
49 Fed. Reg. 5321 (February 10, 1984)
49 Fed. Reg. 25796 (June 22, 1984)
50 Fed. Reg. 1050 (January 9, 1985)
50 Fed. Reg. 4648 (February 1, 1985)
50 Fed. Reg. 9800 (March 12, 1985)
50 Fed. Reg. 36992 (September 11, 1985)
50 Fed. Reg. 37353 (September 13, 1985)
50 Fed. Reg. 41494 (October 11, 1985)
50 Fed. Reg. 51173 (December 13, 1985)
51 Fed. Reg. 22733 (June 20, 1986)
51 Fed. Reg. 24325 (July 3, 1986)
51 Fed. Reg. 25053 (July 10, 1986)
51 Fed. Reg. 33033 (September 18, 1986)
51 Fed. Reg. 33260 (September 19, 1986)
51 Fed. Reg. 34560 (September 29, 1986)
51 Fed. Reg. 45663 (December 19, 1986)
52 Fed. Reg. 16241 (May 4, 1987)
52 Fed. Reg. 17753 (May 12, 1987)
52 Fed. Reg. 34562 (September 11, 1987)
52 Fed. Reg. 36026 (September 25, 1987)
52 Fed. Reg. 36387 (September 28, 1987)
52 Fed. Reg. 46291 (December 4, 1987)
52 Fed. Reg. 49624 (December 31, 1987)
53 Fed. Reg. 6629 (March 2, 1988)
53 Fed. Reg. 8352 (March 14, 1988)
53 Fed. Reg. 11436 (April 6, 1988)
53 Fed. Reg. 12120 (April 12, 1988)

53 Fed. Reg. 16838 (May 11, 1988)
53 Fed. Reg. 17695 (May 18, 1988)
53 Fed. Reg. 27346 (July 20, 1988)
53 Fed. Reg. 27960 (July 26, 1988)
53 Fed. Reg. 34736 (September 8, 1988)
53 Fed. Reg. 35625 (September 14, 1988)
53 Fed. Reg. 37080 (September 23, 1988)
53 Fed. Reg. 38162 (September 29, 1988)
53 Fed. Reg. 39581 (October 7, 1988)
53 Fed. Reg. 45080 (November 8, 1988)
53 Fed. Reg. 47188 (November 22, 1988)
53 Fed. Reg. 49981 (December 13, 1988)
54 Fed. Reg. 2920 (January 19, 1989)
54 Fed. Reg. 6888 (February 15, 1989)
54 Fed. Reg. 9317 (March 6, 1989)
54 Fed. Reg. 12792 (March 28, 1989)
54 Fed. Reg. 28054 (July 5, 1989)
54 Fed. Reg. 29274 (July 11, 1989)
54 Fed. Reg. 29545 (July 13, 1989)
54 Fed. Reg. 30704 (July 21, 1989)
54 Fed. Reg. 31456 (July 28, 1989)
54 Fed. Reg. 31765 (August 1, 1989)
54 Fed. Reg. 36687 (September 1, 1989)
54 Fed. Reg. 36767 (September 5, 1989)
54 Fed. Reg. 37531 (September 11, 1989)
54 Fed. Reg. 41364 (October 6, 1989)
54 Fed. Reg. 46610 (November 6, 1989)
54 Fed. Reg. 47513 (November 15, 1989)
54 Fed. Reg. 49971 (December 4, 1989)
54 Fed. Reg. 50372 (December 6, 1989)
54 Fed. Reg. 52024 (December 20, 1989)
55 Fed. Reg. 3146 (January 30, 1990)
55 Fed. Reg. 3300 (January 31, 1990)
55 Fed. Reg. 3723 (February 5, 1990)
55 Fed. Reg. 4998 (February 13, 1990)
55 Fed. Reg. 7967 (March 6, 1990)
55 Fed. Reg. 12110 (March 30, 1990)
55 Fed. Reg. 12819 (April 6, 1990)
55 Fed. Reg. 13696 (April 11, 1990)
55 Fed. Reg. 14073 (April 13, 1990)
55 Fed. Reg. 19259 (May 9, 1990)
55 Fed. Reg. 25094 (June 10, 1990)
55 Fed. Reg. 26431 (June 28, 1990)
55 Fed. Reg. 32014 (August 6, 1990)
55 Fed. Reg. 38677 (September 20, 1990)
55 Fed. Reg. 46053 (November 1, 1990)
55 Fed. Reg. 46949 (November 8, 1990)
55 Fed. Reg. 50686 (December 10, 1990)
56 Fed. Reg. 15832 (April 18, 1991)
56 Fed. Reg. 24686 (May 31, 1991)
56 Fed. Reg. 43700 (September 4, 1991)
56 Fed. Reg. 64175 (December 6, 1991)

57 Fed. Reg. 6403 (February 24, 1992)
57 Fed. Reg. 7847 (March 4, 1992)
57 Fed. Reg. 7878 (March 5, 1992)
57 Fed. Reg. 22307 (May 27, 1992)
57 Fed. Reg. 24330 (June 8, 1992)
57 Fed. Reg. 24701 (June 10, 1992)
57 Fed. Reg. 27160 (June 18, 1992)
57 Fed. Reg. 29204 (July 1, 1992)
57 Fed. Reg. 29206 (July 1, 1992)
57 Fed. Reg. 35666 (August 10, 1992)
57 Fed. Reg. 42388 (September 14, 1992)
58 Fed. Reg. 4549 (January 14, 1993)
58 Fed. Reg. 15089 (March 19, 1993)
58 Fed. Reg. 16496 (March 29, 1993)
58 Fed. Reg. 21778 (April 23, 1993)
58 Fed. Reg. 34845 (June 29, 1993)
58 Fed. Reg. 35308 (June 30, 1993)
58 Fed. Reg. 35340 (June 30, 1993)
58 Fed. Reg. 40191 (July 27, 1993)
59 Fed. Reg. 4435 (January 31, 1994)
59 Fed. Reg. 6169 (February 9, 1994)
59 Fed. Reg. 16360 (April 6, 1994)
59 Fed. Reg. 26115 (May 19, 1994)
59 Fed. Reg. 33661 (June 30, 1994)
59 Fed. Reg. 33910 (July 1, 1994)
59 Fed. Reg. 36699 (July 19, 1994)
59 Fed. Reg. 40729 (August 9, 1994)
59 Fed. Reg. 41057 (August 10, 1994)
59 Fed. Reg. 43270 (August 22, 1994)
59 Fed. Reg. 51741 (October 12, 1994)
59 Fed. Reg. 65948 (December 22, 1994)
60 Fed. Reg. 9624 (February 21, 1995)
60 Fed. Reg. 11194 (March 1, 1995)
60 Fed. Reg. 33344 (June 28, 1995)
60 Fed. Reg. 33984 (June 29, 1995)
60 Fed. Reg. 47035 (September 8, 1995)
60 Fed. Reg. 52859 (October 11, 1995)
61 Fed. Reg. 5508 (February 13, 1996)
61 Fed. Reg. 9230 (March 7, 1996)
61 Fed. Reg. 9583 (March 8, 1996)
61 Fed. Reg. 19548 (May 2, 1996)
61 Fed. Reg. 21228 (May 9, 1996)
61 Fed. Reg. 31430 (June 20, 1996)
61 Fed. Reg. 43456 (August 23, 1996)
61 Fed. Reg. 56831 (November 4, 1996)
62 Fed. Reg. 1600 (January 10, 1997)
62 Fed. Reg. 29668 (June 2, 1997)
62 Fed. Reg. 40195 (July 25, 1997)
62 Fed. Reg. 42018 (August 4, 1997)
62 Fed. Reg. 42666 (August 8, 1997)
62 Fed. Reg. 43581 (August 14, 1997)
62 Fed. Reg. 48175 (September 15, 1997)

62 Fed. Reg. 54383 (October 20, 1997)
62 Fed. Reg. 65203 (December 11, 1997)
62 Fed. Reg. 66276 (December 18, 1997)
63 Fed. Reg. 1269 (January 8, 1998)
63 Fed. Reg. 13339 (March 19, 1998)
63 Fed. Reg. 17093 (April 8, 1998)
63 Fed. Reg. 20098 (April 23, 1998)
63 Fed. Reg. 33467 (June 18, 1998)
63 Fed. Reg. 50729 (September 22, 1998)
63 Fed. Reg. 66038 (December 1, 1998)
63 Fed. Reg. 66270 (December 1, 1998)
64 Fed. Reg. 13700 (March 22, 1999)
64 Fed. Reg. 13908 (March 23, 1999)
64 Fed. Reg. 22552 (April 27, 1999)
65 Fed. Reg. 76567 (December 7, 2000)
66 Fed. Reg. 5324 (January 18, 2001)
66 Fed. Reg. 18191 (April 6, 2001)
67 Fed. Reg. 67961 (November 7, 2002)
68 Fed. Reg. 75780 (December 31, 2003)
69 Fed. Reg. 7363 (February 17, 2004)
69 Fed. Reg. 31881 (June 8, 2004)
69 Fed. Reg. 46993 (August 4, 2004)
70 Fed. Reg. 53929 (September 13, 2005)
70 Fed. Reg. 1140 (January 5, 2005)
71 Fed. Reg. 10373 (February 28, 2006)
71 Fed. Reg. 36008 (June 23, 2006)
71 Fed. Reg. 63242 (October 30, 2006)
72 Fed. Reg. 7190 (February 14, 2007)
72 Fed. Reg. 64428 (November 15, 2007)
72 Fed. Reg. 71068 (December 14, 2007)
73 Fed. Reg. 75583 (December 12, 2008)
68 Fed. Reg. 32638 (June 2, 2003)
74 Fed. Reg. 46355 (September 9, 2009)
74 Fed. Reg. 40447 (August 11, 2009)
75 Fed. Reg. 12685 (March 17, 2010)
76 Fed. Reg. 33606 (June 8, 2011)
76 Fed. Reg. 75786 (December 5, 2011)
77 Fed. Reg. 17764 (March 26, 2012)
76 Fed. Reg. 80738 (December 27, 2011)
77 Fed. Reg. 37598 (June 22, 2012)
77 Fed. Reg. 46949 (August 7, 2012)
78 Fed. Reg. 9313 (February 8, 2013)
78 Fed. Reg. 69549 (November 20, 2013)
79 Fed. Reg. 20629 (April 11, 2014)
79 Fed. Reg. 56960 (September 24, 2014)
80 Fed. Reg. 60036 (October 5, 2015)
81 Fed. Reg. 16090 (March 25, 2016)
81 Fed. Reg. 16861 (March 25, 2016)
81 Fed. Reg. 82981 (November 18, 2016)
82 Fed. Reg. 2735 (January 9, 2017)
83 Fed. Reg. 19948 (May 7, 2018)
84 Fed. Reg. 21457 (May 14, 2019)

84 Fed. Reg. 50755 (September 26, 2019)

84 Fed. Reg. 68795 (December 17, 2019)

85 Fed. Reg. 8731 (February 18, 2020)

[**ARC 7699B**, IAB 4/8/09, effective 5/13/09; **ARC 8088B**, IAB 9/9/09, effective 10/14/09; **ARC 8395B**, IAB 12/16/09, effective 1/20/10; **ARC 8522B**, IAB 2/10/10, effective 3/17/10; **ARC 8997B**, IAB 8/11/10, effective 9/15/10; **ARC 9755B**, IAB 9/21/11, effective 10/26/11; **ARC 0173C**, IAB 6/13/12, effective 7/18/12; **ARC 0282C**, IAB 8/22/12, effective 9/26/12; **ARC 0726C**, IAB 5/1/13, effective 6/5/13; **ARC 0898C**, IAB 8/7/13, effective 9/11/13; **ARC 1509C**, IAB 6/25/14, effective 7/30/14; **ARC 1531C**, IAB 7/9/14, effective 8/13/14; **ARC 1803C**, IAB 12/24/14, effective 1/28/15; **ARC 2595C**, IAB 6/22/16, effective 7/27/16; **ARC 2959C**, IAB 3/1/17, effective 4/5/17; **ARC 3721C**, IAB 3/28/18, effective 5/11/18; **ARC 4071C**, IAB 10/10/18, effective 11/14/18; **ARC 4640C**, IAB 8/28/19, effective 10/2/19; **ARC 5005C**, IAB 3/25/20, effective 4/29/20; **ARC 5158C**, IAB 8/26/20, effective 9/30/20]

These rules are intended to implement Iowa Code section 88.5.

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- [Filed emergency 7/12/96 after Notice 5/22/96—published 7/31/96, effective 7/31/96]
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- [Filed emergency 11/27/96 after Notice 10/23/96—published 12/18/96, effective 12/18/96]
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- [Filed emergency 9/4/98 after Notice 7/29/98—published 9/23/98, effective 9/23/98]
- [Filed emergency 10/30/98 after Notice 9/23/98—published 11/18/98, effective 11/18/98]
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- [Filed 11/20/01, Notice 6/13/01—published 12/12/01, effective 1/16/02]
- [Filed 3/14/03, Notice 2/5/03—published 4/2/03, effective 5/7/03]
- [Filed emergency 7/16/04 after Notice 6/9/04—published 8/4/04, effective 8/4/04]
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- [Filed 3/29/06, Notice 1/18/06—published 3/29/06, effective 5/3/06]
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[Filed ARC 8395B (Notice ARC 8241B, IAB 10/21/09), IAB 12/16/09, effective 1/20/10]
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[Filed ARC 8997B (Notice ARC 8862B, IAB 6/16/10), IAB 8/11/10, effective 9/15/10]
[Filed ARC 9755B (Notice ARC 9640B, IAB 7/27/11), IAB 9/21/11, effective 10/26/11]
[Filed ARC 0173C (Notice ARC 0105C, IAB 4/18/12), IAB 6/13/12, effective 7/18/12]
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[Filed ARC 2595C (Notice ARC 2516C, IAB 4/27/16), IAB 6/22/16, effective 7/27/16]
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CHAPTER 26
CONSTRUCTION SAFETY AND HEALTH RULES

[Prior to 9/24/86, Labor, Bureau of [530]]

[Prior to 10/7/98, see 347—Ch 26]

875—26.1(88) Adoption by reference. Federal Safety and Health Regulations for Construction beginning at 29 CFR 1926.16 and continuing through 29 CFR, Chapter XVII, Part 1926, are hereby adopted by reference for implementation of Iowa Code chapter 88. These federal rules shall apply and be interpreted to apply to the Iowa Occupational Safety and Health Act, Iowa Code chapter 88, not the Contract Work Hours and Safety Standards Act, and shall apply and be interpreted to apply to enforcement by the Iowa commissioner of labor, not the United States Secretary of Labor or the Federal Occupational Safety and Health Administration. The amendments to 29 CFR 1926 are adopted as published at:

38 Fed. Reg. 16856 (June 27, 1973)
38 Fed. Reg. 27594 (October 5, 1973)
38 Fed. Reg. 33397 (December 4, 1973)
39 Fed. Reg. 19470 (June 3, 1974)
39 Fed. Reg. 24361 (July 2, 1974)
40 Fed. Reg. 23072 (May 28, 1975)
41 Fed. Reg. 55703 (December 21, 1976)
42 Fed. Reg. 2956 (January 14, 1977)
42 Fed. Reg. 37668 (July 22, 1977)
43 Fed. Reg. 56894 (December 5, 1978)
45 Fed. Reg. 75626 (November 14, 1980)
51 Fed. Reg. 22733 (June 20, 1986)
51 Fed. Reg. 25318 (July 11, 1986)
52 Fed. Reg. 17753 (May 12, 1987)
52 Fed. Reg. 36381 (September 28, 1987)
52 Fed. Reg. 46291 (December 4, 1987)
53 Fed. Reg. 22643 (June 16, 1988)
53 Fed. Reg. 27346 (July 20, 1988)
53 Fed. Reg. 29139 (August 2, 1988)
53 Fed. Reg. 35627 (September 14, 1988)
53 Fed. Reg. 35953 (September 15, 1988)
53 Fed. Reg. 36009 (September 16, 1988)
53 Fed. Reg. 37080 (September 23, 1988)
54 Fed. Reg. 15405 (April 18, 1989)
54 Fed. Reg. 23850 (June 2, 1989)
54 Fed. Reg. 30705 (July 21, 1989)
54 Fed. Reg. 41088 (October 5, 1989)
54 Fed. Reg. 45894 (October 31, 1989)
54 Fed. Reg. 49279 (November 30, 1989)
54 Fed. Reg. 52024 (December 20, 1989)
54 Fed. Reg. 53055 (December 27, 1989)
55 Fed. Reg. 3732 (February 5, 1990)
55 Fed. Reg. 42328 (October 18, 1990)
55 Fed. Reg. 47687 (November 14, 1990)
55 Fed. Reg. 50687 (December 10, 1990)
56 Fed. Reg. 2585 (January 23, 1991)
56 Fed. Reg. 5061 (February 7, 1991)
56 Fed. Reg. 41794 (August 23, 1991)
56 Fed. Reg. 43700 (September 4, 1991)

57 Fed. Reg. 7878 (March 5, 1992)
57 Fed. Reg. 24330 (June 8, 1992)
57 Fed. Reg. 29119 (June 30, 1992)
57 Fed. Reg. 35681 (August 10, 1992)
57 Fed. Reg. 42452 (September 14, 1992)
58 Fed. Reg. 21778 (April 23, 1993)
58 Fed. Reg. 26627 (May 4, 1993)
58 Fed. Reg. 35077 (June 30, 1993)
58 Fed. Reg. 35310 (June 30, 1993)
58 Fed. Reg. 40468 (July 28, 1993)
59 Fed. Reg. 215 (January 3, 1994)
59 Fed. Reg. 6170 (February 9, 1994)
59 Fed. Reg. 36699 (July 19, 1994)
59 Fed. Reg. 40729 (August 9, 1994)
59 Fed. Reg. 41131 (August 10, 1994)
59 Fed. Reg. 43275 (August 22, 1994)
59 Fed. Reg. 65948 (December 22, 1994)
60 Fed. Reg. 9625 (February 21, 1995)
60 Fed. Reg. 11194 (March 1, 1995)
60 Fed. Reg. 33345 (June 28, 1995)
60 Fed. Reg. 34001 (June 29, 1995)
60 Fed. Reg. 36044 (July 13, 1995)
60 Fed. Reg. 39255 (August 2, 1995)
60 Fed. Reg. 50412 (September 29, 1995)
61 Fed. Reg. 5509 (February 13, 1996)
61 Fed. Reg. 9248 (March 7, 1996)
61 Fed. Reg. 31431 (June 20, 1996)
61 Fed. Reg. 41738 (August 12, 1996)
61 Fed. Reg. 43458 (August 23, 1996)
61 Fed. Reg. 46104 (August 30, 1996)
61 Fed. Reg. 56856 (November 4, 1996)
61 Fed. Reg. 59831 (November 25, 1996)
62 Fed. Reg. 1619 (January 10, 1997)
63 Fed. Reg. 1295 (January 8, 1998)
63 Fed. Reg. 1919 (January 13, 1998)
63 Fed. Reg. 3814 (January 27, 1998)
63 Fed. Reg. 13340 (March 19, 1998)
63 Fed. Reg. 17094 (April 8, 1998)
63 Fed. Reg. 20099 (April 23, 1998)
63 Fed. Reg. 33468 (June 18, 1998)
63 Fed. Reg. 35138 (June 29, 1998)
63 Fed. Reg. 66274 (December 1, 1998)
64 Fed. Reg. 22552 (April 27, 1999)
66 Fed. Reg. 5265 (January 18, 2001)
66 Fed. Reg. 37137 (July 17, 2001)
67 Fed. Reg. 57736 (September 12, 2002)
69 Fed. Reg. 31881 (June 8, 2004)
70 Fed. Reg. 1143 (January 5, 2005)
71 Fed. Reg. 2885 (January 18, 2006)
70 Fed. Reg. 76985 (December 29, 2005)
71 Fed. Reg. 10381 (February 28, 2006)
71 Fed. Reg. 36008 (June 23, 2006)

71 Fed. Reg. 76985 (August 24, 2006)
 72 Fed. Reg. 64428 (November 15, 2007)
 73 Fed. Reg. 75583 (December 12, 2008)
 75 Fed. Reg. 12685 (March 17, 2010)
 75 Fed. Reg. 27429 (May 17, 2010)
 75 Fed. Reg. 48130 (August 9, 2010)
 76 Fed. Reg. 33606 (June 8, 2011)
 77 Fed. Reg. 17764 (March 26, 2012)
 76 Fed. Reg. 80738 (December 27, 2011)
 77 Fed. Reg. 23118 (April 18, 2012)
 77 Fed. Reg. 37598 (June 22, 2012)
 77 Fed. Reg. 42988 (July 23, 2012)
 77 Fed. Reg. 46949 (August 7, 2012)
 78 Fed. Reg. 23841 (April 23, 2013)
 78 Fed. Reg. 32116 (May 29, 2013)
 79 Fed. Reg. 20629 (April 11, 2014)
 79 Fed. Reg. 56960 (September 24, 2014)
 79 Fed. Reg. 57798 (September 26, 2014)
 80 Fed. Reg. 25518 (May 4, 2015)
 80 Fed. Reg. 60039 (October 5, 2015)
 81 Fed. Reg. 16092 (March 25, 2016)
 81 Fed. Reg. 16875 (March 25, 2016)
 83 Fed. Reg. 56244 (November 9, 2018)
 84 Fed. Reg. 21574 (May 14, 2019)
 85 Fed. Reg. 8735 (February 18, 2020)
 85 Fed. Reg. 53997 (August 31, 2020)
 85 Fed. Reg. 57122 (September 15, 2020)

This rule is intended to implement Iowa Code sections 84A.1, 84A.2, 88.2 and 88.5.

[ARC 7699B, IAB 4/8/09, effective 5/13/09; ARC 8997B, IAB 8/11/10, effective 9/15/10; ARC 9230B, IAB 11/17/10, effective 12/22/10; ARC 9755B, IAB 9/21/11, effective 10/26/11; ARC 0173C, IAB 6/13/12, effective 7/18/12; ARC 0282C, IAB 8/22/12, effective 9/26/12; ARC 0726C, IAB 5/1/13, effective 6/5/13; ARC 0898C, IAB 8/7/13, effective 9/11/13; ARC 1049C, IAB 10/2/13, effective 11/6/13; ARC 1531C, IAB 7/9/14, effective 8/13/14; ARC 1803C, IAB 12/24/14, effective 1/28/15; ARC 1908C, IAB 3/18/15, effective 4/22/15; ARC 2136C, IAB 9/16/15, effective 10/21/15; ARC 2595C, IAB 6/22/16, effective 7/27/16; ARC 4320C, IAB 2/27/19, effective 4/3/19; ARC 4640C, IAB 8/28/19, effective 10/2/19; ARC 5158C, IAB 8/26/20, effective 9/30/20; ARC 5490C, IAB 3/10/21, effective 4/14/21]

875—26.2(88) Beryllium exposure limits. Effective May 11, 2018, the eight-hour time-weighted average permissible exposure limit for beryllium is 0.2 micrograms per cubic liter, and the short-term exposure limit for beryllium is 2.0 micrograms per cubic meter over a 15-minute sampling period.

This rule is intended to implement Iowa Code section 88.5.

[ARC 3721C, IAB 3/28/18, effective 5/11/18]

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