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

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

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

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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

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

Agriculture and Land Stewardship Department[21]

Replace Chapter 85

Capital Investment Board, Iowa[123]

Replace Chapter 4

Human Services Department[441]

Replace Chapters 51 and 52
Replace Chapter 78

Public Health Department[641]

Replace Analysis
Replace Reserved Chapter 8 with Chapter 8
Replace Reserved Chapter 10 with Chapter 10
Replace Chapter 37 with Reserved Chapter 37
Replace Chapter 85
Replace Chapters 131 and 132

Pharmacy Board[657]

Replace Chapter 37

Revenue Department[701]

Replace Analysis
Replace Chapter 40

Veterans Affairs, Iowa Department of[801]

Replace Analysis
Replace Chapter 11
Replace Chapter 12 with Reserved Chapter 12
Replace Chapter 14
Insert Chapter 17

CHAPTER 85
WEIGHTS AND MEASURES

[Appeared as Ch 14, 1973 IDR]
[Certain rules renumbered 5/3/78]
All tolerances and specifications for the weights and measures division were adopted from the U.S. Bureau of Standards Handbook II, 44 published September 1949.
[Prior to 7/27/88 see Agriculture Department 30—Ch 55]

WEIGHTS

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

This rule is intended to implement Iowa Code section 215.18.

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

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

21—85.4 Reserved.

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

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

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

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

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

This rule is intended to implement Iowa Code section 215.18.

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

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

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

This rule is intended to implement Iowa Code section 215.18.

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

This rule is intended to implement Iowa Code section 215.18.

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

This rule is intended to implement Iowa Code section 215.18.

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

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

This rule is intended to implement Iowa Code section 215.18.

21—85.11(215) Scale pit.

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

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

This rule is intended to implement Iowa Code section 215.15.

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

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

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

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

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

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

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

This rule is intended to implement Iowa Code section 215.18.

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

This rule is intended to implement Iowa Code section 215.17.

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

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

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

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

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

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

This rule is intended to implement Iowa Code section 215.18.

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

This rule is intended to implement Iowa Code section 215.18.

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

This rule is intended to implement Iowa Code section 215.18.

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

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

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

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

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

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

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

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

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

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

This rule is intended to implement Iowa Code section 215.16.

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

This rule is intended to implement Iowa Code section 215.18.

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

This rule is intended to implement Iowa Code section 215.18.

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

This rule is intended to implement Iowa Code section 215.18.

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

This rule is intended to implement Iowa Code section 215.10.

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

This rule is intended to implement Iowa Code section 215.1.

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

This rule is intended to implement Iowa Code section 215.18.

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

This rule is intended to implement Iowa Code section 215.18.

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

This rule is intended to implement Iowa Code section 215.18.

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

This rule is intended to implement Iowa Code section 215.18.

SCALES

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

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

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

21—85.30 to **85.32** Reserved.

MEASURES

21—85.33(214A,208A) Motor fuel and antifreeze tests and standards. In the interest of uniformity, the tests and standards for motor fuel, including but not limited to renewable fuels such as ethanol blended gasoline, biodiesel, biodiesel blended fuel, and components such as an oxygenate, raffinate natural gasoline and motor vehicle antifreeze shall be those established by the American Society for Testing and Materials (ASTM) in effect on October 1, 2006. Diesel fuel which does not comply with ASTM international specifications may be stored in Iowa only if the diesel fuel is stored at a terminal for the purposes of blending the diesel fuel with biodiesel so that the finished biodisel blended product does meet the applicable specifications. In addition, a motor fuel that contains more than one-half of 1 percent of methyl tertiary butyl ether (MTBE) by volume shall not be sold, offered for sale, or stored in Iowa.

This rule is intended to implement Iowa Code sections 208A.5, 208A.6 and 215.18 and 2006 Iowa Acts, House File 2754.

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

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

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

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

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

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

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

This rule is intended to implement Iowa Code section 215.20.

21—85.36(215) Recording elements. All weighing or measuring devices shall be provided with appropriate recording or indicating elements, which shall be definite, accurate and easily read under

any conditions of normal operation of the device. Graduations and a suitable indicator shall be provided in connection with indications and recorded representations designed to advance continuously. Graduations shall not be required in connection with indications or recorded representations designed to advance intermittently or with indications or recorded representations of the selector type.

This rule is intended to implement Iowa Code section 215.18.

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

This rule is intended to implement Iowa Code section 215.18.

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

This rule is intended to implement Iowa Code section 215.18.

21—85.39(189,215) Weights and measures. The specifications, tolerances and regulations for commercial weighing and measuring devices, together with amendments thereto, as recommended by the National Institute of Standards and Technology and published in National Institute of Standards and Technology Handbook 44 amended or revised as of July 16, 2009, shall be the specifications, tolerances and regulations for commercial weighing and measuring devices in the state of Iowa, except as modified by state statutes, or by rules adopted and published by the Iowa department of agriculture and land stewardship and not rescinded.

The National Institute of Standards and Technology (NIST) Handbooks 130 and 133: Weights and Measures Law, Packaging and Labeling, Method of Sale, Type Evaluation and Checking the Net Contents of Packaged Goods, and all supplements, as promulgated by the National Institute of Standards and Technology amended or revised as of July 16, 2009, are adopted in their entirety by this reference.

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

[**ARC 8292B**, IAB 11/18/09, effective 12/23/09]

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

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

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

This rule is intended to implement Iowa Code section 215.5.

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

This rule is intended to implement Iowa Code section 215.5.

21—85.42(215) Security seal. In accordance with the contemplated revision of National Institute of Standards and Technology Handbook 44, Gur. 4.4 (Replacement of Security Seal), accredited repair and testing companies shall be authorized to affix a security seal, properly marked with the identification of such company.

This rule is intended to implement Iowa Code section 215.12.

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

This rule is intended to implement Iowa Code section 215.20.

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

This rule is intended to implement Iowa Code section 215.20.

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

This rule is intended to implement Iowa Code section 215.20.

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

This rule is intended to implement Iowa Code section 215.20.

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

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

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

85.48(2) Petroleum product retailers, if they elect to advertise the unit price of their petroleum products at or near the curb, storefront or billboard, shall display the price per gallon or liter. The advertised price shall equal the computer price settings shown on the metering pump.

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

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

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

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

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

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

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

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

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

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

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

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

a. The only two sizes of decals approved are the following:

(1) A design of 1.25″ by 4″.

(2) A design of 2″ by 6″.

b. All labels shall have the word "with" in letters a minimum of .1875″ high, and the name of the renewable fuel in letters a minimum of .5″ high.

c. The use of color, design and wording shall be approved by the renewable fuels and coproducts advisory committee. The coordinator may receive input from any party including the weights and measures bureau of the department in recommending the color, design, and wording. The advisory committee shall approve the color, design, and wording to promote the use of renewable fuels.

d. All black and white fuel pump stickers shall be replaced by approved colorful fuel pump decals effective July 1, 1995.

e. Biodiesel fuel containing 5 percent or less of biodiesel does not require the biodiesel label.

f. Biodiesel fuel containing more than 5 percent but not more than 20 percent of renewable fuel must indicate on the label whether biodiesel or biomass-based diesel is the renewable fuel contained in the product. The label must also indicate that the fuel contains biodiesel or biomass-based diesel in quantities greater than 5 percent but not more than 20 percent. A specific blend percentage is not required on the label.

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

85.48(11) Ethanol blended gasoline classified as higher than E-15 shall have a visible, legible "for flex fuel vehicle only" sticker on the pump or pump handle.

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

85.48(13) Rescinded IAB 3/11/09, effective 4/15/09.

85.48(14) Octane rating of fuel offered for sale shall be posted on the pump in a conspicuous place. The octane rating shall be posted for registered fuels. No octane rating shall be posted on the pump for ethanol blended gasoline classified as higher than E-15.

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

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

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

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

[**ARC 7628B**, IAB 3/11/09, effective 4/15/09; **ARC 8434B**, IAB 12/30/09, effective 2/3/10; **ARC 0079C**, IAB 4/4/12, effective 3/16/12]

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

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

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

This rule is intended to implement Iowa Code section 214A.2.

[**ARC 7628B**, IAB 3/11/09, effective 4/15/09; **ARC 0079C**, IAB 4/4/12, effective 3/16/12]

21—85.51 Reserved.

MOISTURE-MEASURING DEVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21—85.58 to **85.62** Reserved.

HOPPER SCALES

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

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

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

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

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

[IDR 1952, p.20, 1954, 1958, 1962]
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CHAPTER 4
INVESTMENT TAX CREDITS RELATING TO INVESTMENTS IN A FUND OF FUNDS ORGANIZED BY THE IOWA CAPITAL INVESTMENT CORPORATION

123—4.1(15E) Contingent tax credits relating to investments in Iowa fund of funds. Contingent tax credits are available for designated investors in the Iowa fund of funds organized by the Iowa capital investment corporation in accordance with Iowa Code section 15E.65. Tax credit certificates related to the contingent tax credits will be issued by the Iowa capital investment board. If the tax credit certificates are redeemed, a taxpayer may claim a credit against the taxpayer's tax liability for personal net income tax imposed under Iowa Code chapter 422, division II; business tax on corporations imposed under Iowa Code chapter 422, division III; taxation of financial institutions imposed under Iowa Code chapter 422, division V; taxation of insurance companies imposed under Iowa Code chapter 432; or taxation of credit unions imposed under Iowa Code section 533.24.

123—4.2(15E) Definitions. The following definitions are applicable to this chapter:

"Act" means Iowa Code sections 15E.61 through 15E.69.

"Actual return" means the actual aggregate amount of moneys or the fair market value of property received from a fund of funds by a designated investor, with respect to an investment amount for which a certificate is issued, including amounts received as returns of invested capital or returns on invested capital and amounts received in excess of invested capital, in whatever form received for the period from the date of the closing to the applicable maturity date.

"Board" means the Iowa capital investment board created under Iowa Code section 15E.63.

"Certificate" or *"tax credit certificate"* means a document constituting a contract between the state of Iowa and a holder and evidencing a tax credit that has been issued and, subject to the contingencies described on the certificate, that may become available to the holder.

"Certificate register" means the register to be maintained by the department recording the name, address, and taxpayer identification number of each holder and the maximum potential amount of the tax credits represented by each certificate issued to each holder.

"Closing" means a time when a certificate is issued to a designated investor in exchange for a commitment to contribute cash to the capital of a fund of funds.

"Commitment" or *"commits"* means either a binding obligation undertaken at a closing to invest in a fund of funds in the future or an actual investment made in a fund of funds, but without counting the same amount twice.

"Contingencies" shall mean the conditions under which a tax credit may be claimed and shall include each of the following:

1. The condition that the tax credits may only be used to the extent that the actual return on the investment amount associated with the certificate is less than the applicable scheduled return on such investment amount, and then only to the extent such tax credit becomes a verified tax credit;
2. The condition that the amount of the total verified tax credits represented by such certificate that first may be claimed during any redemption year will be limited to the amount verified by the board to the department;
3. The condition that no amount of the tax credit may be claimed prior to a maturity date stated on the certificate; and
4. The condition that receipt by the designated investor of an actual return on the investment amount associated with the certificate equal to the scheduled return on such investment amount will result in the cancellation of the tax credit certificate.

"Day" means any weekday Monday through Friday that is not a legal holiday in the state of Iowa.

"Department" means the Iowa department of revenue.

"Designated investor" means a natural person or an entity, other than the Iowa capital investment corporation or the revolving fund, that has committed to contribute capital to a fund of funds, and such person's or entity's successors and assignees.

"Fiscal year" means the fiscal year for the state of Iowa.

"Fund of funds" means any private, for-profit limited partnership or limited liability company established by the Iowa capital investment corporation to which a designated investor commits to make a capital contribution.

"Holder" means a holder of a tax credit certificate, either as a designated investor or as a transferee of a designated investor, as reflected on the certificate register.

"Investment amount" means the amount of cash contributed by a designated investor to a fund of funds with respect to which a certificate has been issued.

"Iowa capital investment corporation" means the private, nonprofit corporation created pursuant to Iowa Code section 15E.64.

"Maturity date" means a specific date or dates specified in a certificate, representing the earliest date on which a holder of the certificate may use it to satisfy tax liabilities.

"Percentage of return" means the percentage represented by the quotient of (1) the actual return for a designated investor on the investment amount associated with a certificate divided by (2) the scheduled return for such designated investor on such investment amount.

"Portfolio entity" means a venture capital fund or direct investment entity in which a fund of funds makes an investment.

"Redeem" means, with respect to a certificate, to present such certificate to the department as payment for tax liabilities due or to become due on or after the date of such presentation.

"Redemption year" means each calendar year for which verified tax credits associated with a certificate may first be utilized to reduce tax liabilities.

"Revolving fund" means the private, for-profit limited liability company established by the Iowa capital investment corporation as a revolving fund of funds pursuant to Iowa Code section 15E.65.

"Scheduled return" means the scheduled return, whether in money or property, (including returns of and returns on investment) with respect to an investment amount associated with a certificate issued to a designated investor in a fund of funds determined in accordance with the limited partnership agreement or the operating agreement of such fund of funds for the period from the date of the closing to the applicable maturity date. If relevant for determining the amount of the scheduled return, the board shall presume that a verified tax credit will be transferred at 100 percent of the amount stated on the verified tax credit. It shall be the burden of a designated investor to show that the verified tax credit cannot be transferred without discounting the amount stated on such credit.

"Tax credit" means a contingent tax credit authorized pursuant to Iowa Code section 15E.66 that is available against tax liabilities up to the amount stated on the certificate for such tax credit.

"Tax liabilities" means those tax liabilities identified in rule 123—4.1(15E).

"Verified tax credits" means tax credits that have been verified by the board to the department and to the holder of the certificate that represents such tax credits. In the event that the verified tax credits are different from the amount certified by the Iowa capital investment corporation, the amount verified by the board shall control.

[**ARC 0076C**, IAB 4/4/12, effective 4/4/12]

123—4.3(15E) Report of the Iowa capital investment corporation. No less than ten days prior to each closing, the Iowa capital investment corporation shall deliver a written report to the board and to the department containing the following information:

1. A copy of the certificate of limited partnership or articles of organization of the fund of funds for which the closing is scheduled, certified by the Iowa secretary of state;
2. A summary of the terms of the anticipated investments in such fund of funds as contained in the limited partnership agreement or the operating agreement of the fund of funds; and
3. A statement of the anticipated date of the closing.

No less than two days prior to each closing, the Iowa capital investment corporation shall deliver to the board a signed statement of an officer of the Iowa capital investment corporation certifying the names, addresses and taxpayer identification numbers of the persons expected to be designated investors at the closing, the total amount of the capital commitments expected to be received at the closing, the maximum amount of tax credits to be represented by each certificate to be issued at the closing, the date

of the anticipated closing, the maturity date or dates for each certificate to be issued at the closing, the contingencies applicable to the tax credits, and the calculation formula for determining the scheduled return.

123—4.4(15E) Allocation and issuance of certificates. Certificates shall be issued only by the board and only with respect to an actual capital commitment to a fund of funds.

Following receipt of the certification of the Iowa capital investment corporation pursuant to rule 123—4.3(15E), the board shall issue a certificate to each such designated investor at the closing. The maximum amount of tax credits represented by each certificate shall be calculated in accordance with the limited partnership agreement or operating agreement of the applicable fund of funds. The board shall not issue certificates if, in the aggregate, the maximum amount of tax credits represented by all issued and uncanceled certificates at any time would exceed $60 million (less the aggregate amount of any tax credits that have been used to reduce tax liabilities) calculated in accordance with Iowa Code section 15E.66.

A tax credit certificate shall contain, or incorporate by reference to another document, each of the following:

1. The name, address, and tax identification number of the holder;
2. The investment amount committed upon issuance of that certificate and (if applicable) the class of interests issued to the designated investor that has committed to make such investment amount;
3. All of the contingencies applicable to the tax credits;
4. The date of issue of the certificate;
5. The maximum amount of the tax credit represented by the certificate;
6. The maturity date or dates of the certificate;
7. The calculation formula for determining the scheduled return;
8. The calculation formula for determining the amount of the tax credit that may be used to reduce tax liabilities;
9. If the certificate is issued upon a transfer after verification in accordance with 123—4.5(15E), the amount of the verified tax credits represented by such certificate and the redemption year(s) for which they may be used to reduce tax liabilities; and
10. A statement that, although the certificate is not considered a security pursuant to Iowa Code chapter 502, the certificate constitutes a security as such term is defined in Iowa Code section 554.8102(1)*"o"* solely for purposes of the creation, perfection, priority and enforcement of security interests.

[**ARC 9030B**, IAB 8/25/10, effective 9/29/10]

123—4.5(15E) Procedures for verification of tax credits.

4.5(1) At any time after the applicable maturity date for a certificate, the holder may present such certificate to the Iowa capital investment corporation for certification. Within ten days after receipt of such certificate, the Iowa capital investment corporation shall certify to the board the percentage of return for the designated investor for such certificate. If the percentage of return is less than 100 percent, the Iowa capital investment corporation shall certify the resulting total amount of tax credits to be verified for use by the holder of such certificate in accordance with the terms of the limited partnership agreement or the operating agreement of the fund of funds. The Iowa capital investment corporation shall give notice of such percentage of return and such amount of tax credits to the holder of such certificate at the holder's address as it appears on the certificate register.

4.5(2) The Iowa capital investment corporation, and any entity with which the corporation has entered into agreements pursuant to the investments and financial transactions described in Iowa Code chapter 15E, division VII, shall provide all documents that the board finds are, or may become, necessary for the board to verify the amount of tax credits to be issued pursuant to this chapter. Such documents include but are not limited to the following:

a. Financial transactions related to the Iowa capital investment corporation, the Iowa fund of funds, designated investors, lenders, or portfolio entities.

b. Financial documents, loan agreements, and security instruments to which any of the Iowa capital investment corporation, the Iowa fund of funds, designated investors, lenders, or a portfolio entity is a party.

c. Investment agreements to which any of the Iowa capital investment corporation, the Iowa fund of funds, designated investors, lenders, or a portfolio entity is a party.

d. All legal documents and correspondence related to the documents described in paragraphs 4.5(2)*"a"* through 4.5(2)*"c"* to which any of the Iowa capital investment corporation, the Iowa fund of funds, designated investors, lenders, or a portfolio entity is a party.

e. All documents and financial information necessary to calculate the actual return, the scheduled return, and the percentage of return.

f. Any other documents the board deems necessary to assess compliance with Iowa Code chapter 15E, division VII, or this chapter or to correctly verify the amount of tax credits related to a certificate issued pursuant to this chapter.

4.5(3) Within 30 days of the receipt of all documents and information pursuant to subrule 4.5(2), the board shall establish and verify the amount of tax credits related to that certificate, if any, that may be initially used in each redemption year so that no more than $20 million in tax credits, in the aggregate, may become useable to reduce tax liabilities in any fiscal year (provided that such $20 million limitation shall not limit the carryforward of tax credits otherwise authorized by the Act or these rules). Except to the extent specifically required by the $20 million annual limitation, all tax credits relating to a verified certificate shall be useable to satisfy tax liabilities for a tax year beginning on or after the maturity date and ending at the expiration of the carryforward period specified in rule 123—4.10(15E).

4.5(4) The board shall issue to the holder of such certificate a verification setting forth (a) the amount of verified tax credits represented by such certificate (if any) and (b) the amount of verified tax credits represented by such certificate that may first become useable to reduce tax liabilities in any redemption year (if any).

4.5(5) If the verified certificate has more than one maturity date, the board shall issue to the holder a certificate for the verified tax credits. The verified certificate will contain no contingencies. The board shall issue one or more balance certificates for any maturity dates for which tax credits are not then being verified.

4.5(6) Certificates being verified for a maturity date shall be verified pro rata with all other certificates being verified for the same maturity date.

4.5(7) If a contingent certificate has more than one maturity date, the most recent maturity date prior to the date on which the certificate was presented to the board for verification shall be the maturity date used for purposes of verification under this rule.

[**ARC 0076C**, IAB 4/4/12, effective 4/4/12]

123—4.6(15E) Contractual nature of certificates; irrevocability of tax credits. Upon the issuance of a certificate, the entitlement of a holder to use the tax credits represented by the certificate shall be final and permanent, subject only to the contingencies expressly stated or incorporated by reference in the certificate, and such entitlement shall not be subject to any further condition, reduction, modification, amendment, change, revocation, or recapture.

The entitlement of a holder to claim tax credits represented by a certificate shall constitute a contract between the state of Iowa on the one hand and such holder and the holder's successors and assignees on the other hand which shall not be subject to modification, amendment, change or rescission without prior written consent of the holder as of the date of any such purported action. No such modification, amendment, change or rescission to which a holder may have agreed shall be binding upon any of the successors or assignees of such holder unless it is stated in the text of the certificate issued to such successor or assignee.

The entitlement of a holder to claim tax credits represented by such certificate shall not be affected in any way or become subject to forfeiture or recapture by:

1. Action or inaction of the holder or designated investor;

2. The transfer by the designated investor of all or any portion of the designated investor's interest in a fund of funds;

3. The determination after the closing that a fund of funds was not organized or did not make its investments in accordance with the requirements of the Act or these rules;

4. The invalidity or illegality for any reason of the existence or functions of the board, the revolving fund, a fund of funds or the Iowa capital investment corporation or the investments made by a fund of funds or one or more of the portfolio entities;

5. The bankruptcy, insolvency, reorganization, merger, consolidation, dissolution or liquidation of the board, the revolving fund, any fund of funds, the Iowa capital investment corporation or any portfolio entity for any reason; or

6. The level, timing, or degree of success of any fund of funds or any portfolio entities, or the extent to which venture capital funds that are portfolio entities are invested in Iowa venture capital projects, or are successful in accomplishing any economic development objective.

If the legal existence of the board, the revolving fund, a fund of funds, the Iowa capital investment corporation or the department is ended or some or all of its respective functions are transferred to another entity at any time prior to the full use of 100 percent of the tax credits that could potentially be represented by all of the certificates, the board or its successor (or the state of Iowa if the legal existence of the board ends or the board ceases to have the requisite authority and there is no successor with such authority) shall adopt such rules as may be necessary to ensure the continuity and effectiveness of the entitlement of each holder to use the tax credits represented by such holder's certificate.

Upon the closing, a certificate shall be binding on the board, the department, and the state of Iowa, and the tax credits represented thereby shall not be modified, terminated, or rescinded or subject to recapture.

123—4.7(15E) Transfer of tax credit certificates. Certificates shall be transferable by the holders and any subsequent holders to any transferee or transferees.

Transfer of a certificate may be effected only by the holder's surrender of the certificate to the board with an endorsement in favor of the transferee, or transferees, and a statement containing the name, address and tax identification number of the transferee, and a written request for the board to issue a replacement certificate or certificates in the name of the transferee(s) (as well as, in any case where the transferor requests that more than one replacement certificate be issued, a statement by the transferor that sets forth the aggregate amount of tax credits represented by the transferred certificate that are to be represented by each replacement certificate).

Within ten days after the surrender and endorsement of a certificate, the board shall issue a replacement certificate or certificates in the name of the transferee(s). Once a transferor of a certificate has surrendered a certificate to the board, such transferor may no longer use the tax credits represented by such certificate.

A holder shall have the right to pledge and grant security interests in certificates and tax credits held by such holder as collateral for loans to or other obligations of such holder.

123—4.8(15E) Cancellation of tax credits upon receipt of scheduled return. Tax credits represented by a certificate are subject to cancellation only as provided in the certificate and upon receipt by the designated investor of an actual return equal to the designated investor's scheduled return with respect to such certificate. At the time of each distribution to a designated investor in a fund of funds, the Iowa capital investment corporation shall determine the amount of tax credits related to each certificate that have been canceled and have become null and void by reason of such distribution, if any, and shall certify such amount to the board. After any such certification, the board shall certify to the holder of each such certificate, at the holder's address as shown on the certificate register, and to the department the amount of tax credits that are deemed to have been canceled and to be null and void. If at any time prior to a verification of a certificate the actual return of a designated investor shall equal the designated investor's scheduled return with respect to such certificate, and all other conditions for cancellation contained in the certificate have been met, the Iowa capital investment corporation shall so certify to the board. After any

such certification, the board shall certify to such holder at the holder's address as shown on the certificate register and to the department that such certificates shall be deemed to have been canceled and to be null and void. Tax credits that are canceled may be reissued with respect to the same or another fund of funds.

123—4.9(15E) Lost or mutilated tax credit certificates. Upon receipt of evidence satisfactory to the board of the loss, theft, destruction or mutilation of any certificate, and in case of any such loss, theft or destruction, upon delivery of any indemnity agreement satisfactory to the board, or in case of any such mutilation, upon surrender and cancellation of such certificate, the board shall issue and deliver to the holder a replacement certificate within ten days.

123—4.10(15E) Claiming the tax credits. The holder shall attach a copy of the verification or (if the applicable certificate has been transferred after the date of such verification) a copy of the certificate issued to such holder to any tax return in which verified tax credits are used to reduce tax liabilities. Verified tax credits may be carried forward by the holder for use in any of the seven calendar years following the initial redemption year. Verified tax credits may be used to make estimated tax payments insofar as the holder may take the amount of the tax credit into account in calculating the holder's estimated annual tax liability, thus reducing or eliminating the amount of estimated tax that would otherwise be payable. Verified tax credits not used after the expiration of such seven-calendar-year period shall be deemed to have been canceled and to be null and void and may be reissued in respect to the same or another fund of funds.

The following nonexclusive examples illustrate how this rule applies:

EXAMPLE 1: Holder X has redeemed Holder X's tax credit certificate and received verification from the board authorizing the use of the following amounts of tax credits to reduce tax liabilities in the indicated years: 2010: $700,000; 2011: $140,000; 2012: $70,000. Holder X has zero Iowa tax liability in 2010, $900,000 of tax liabilities in 2011 and $100,000 of tax liabilities in 2012. Holder X may carry forward the $700,000 in tax credits that were first useable in 2010. Holder X may use up to $840,000 of tax credits in 2011 and $70,000 in 2012.

EXAMPLE 2: Holder X has redeemed Holder X's tax credit certificate and received verification from the board authorizing the use of tax credits to reduce tax liabilities that are the same as in Example 1. Holder X has zero in Iowa taxable income in each of the years 2010 through 2014. Holder X may carry forward the $700,000 of tax credits attributable to 2010 and use such tax credits in years 2015, 2016 and 2017 (i.e., up to seven tax years after 2010). To the extent that the $700,000 of tax credits attributable to 2010 is not used by 2017, Holder X may no longer use such tax credits. Holder X may carry forward the $140,000 of tax credits attributable to 2011 and use such tax credits in years 2015, 2016, 2017 and 2018 (i.e., up to seven tax years after 2011). To the extent that the $140,000 of tax credits attributable to 2011 is not used by 2018, Holder X may no longer use such tax credits. Holder X may carry forward the $70,000 of tax credits attributable to 2012 and use such tax credits in years 2015, 2016, 2017, 2018 and 2019 (i.e., up to seven tax years after 2012). To the extent that the $70,000 of tax credits attributable to 2012 is not used by 2019, Holder X may no longer use such tax credits.

EXAMPLE 3: Holder X has redeemed Holder X's tax credit certificate and received verification from the board authorizing the use of tax credits to reduce tax liabilities that are the same as in Example 1. In 2011, Holder X actually uses $840,000 of tax credits to reduce an equal amount of tax liabilities (reducing Holder X's tax liabilities in 2011 to zero). In 2014, as a result of an audit, Holder X's tax liabilities for 2011 are changed to $700,000. That adjustment creates $140,000 in tax credits that were not actually useable in 2011. Holder X may use this $140,000 of tax credits in years 2012 through 2018.

If a holder is a partnership (whether general, limited or limited liability), limited liability company that has not elected to be taxed as a corporation for federal income tax purposes, or a corporation for which a valid Iowa "S" election is in effect, and such holder has no tax liability because only the partners, members or shareholders of such holder are subject to the tax liabilities imposed by the state of Iowa and described in section 15E.62(6) of the Act, the holder may allocate the tax credits represented by the holder's certificate among the holder's partners, members or shareholders. Such allocation shall be

made on the basis of the pro rata share of earnings from the partnership, limited liability company, or S corporation calculated in accordance with the organizational documents of the holder.

If a holder is an estate or trust, the tax credits represented by the holder's certificate shall be allocated to such estate or trust or to such other person to whom the income of such estate or trust is taxed in proportion to each such person's actuarial interest in such estate or trust.

123—4.11(15E) Notification to the department of revenue. Upon the issuance, distribution, redemption, or transfer of tax credit certificates, the board shall provide copies of the tax credit certificates or replacement certificates to the department of revenue.

123—4.12(15E) Other provisions. The department shall maintain the certificate register at its principal office. The certificate register shall be open to inspection by holders during the department's normal business hours. The department shall, upon request, issue confirmation as to the ownership of a certificate or entitlement to tax credits. The certificate registry is the conclusive record of holders and their entitlements to tax credits.

All notices, requests, and submissions required to be sent to the board shall be sent to the Iowa Capital Investment Board in care of the Iowa Department of Revenue, 1305 E. Walnut Street, Hoover State Office Building, Des Moines, Iowa 50319.

Each fund of funds shall principally make investments in venture capital funds managed by investment managers who have made a commitment to consider equity investments in businesses located within the state of Iowa and who have committed to maintain a physical presence within the state of Iowa. For purposes of this requirement, a physical presence in Iowa includes, but is not limited to, having an office or other business location in Iowa or having employees or representatives present in Iowa on a regular and continuing basis.

123—4.13(15E) Redemption date and priority of tax credits with respect to limited partnership interests in the Iowa fund of funds, Fund A. Rescinded IAB 4/13/05, effective 3/25/05.

123—4.14(15E) Scheduled return and tax credits represented by certificates issued with respect to Class C limited partnership interests in Fund A. Rescinded IAB 4/13/05, effective 3/25/05.

123—4.15(15E) Scheduled return and tax credits represented by certificates issued with respect to Class A limited partnership interests in the Iowa fund of funds, Fund A. Rescinded IAB 4/13/05, effective 3/25/05.

123—4.16(15E) Scheduled return and tax credits represented by certificates issued with respect to Class D limited partnership interests in Fund A. Rescinded IAB 4/13/05, effective 3/25/05.

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CHAPTER 51
ELIGIBILITY

[Prior to 7/1/83, Social Services[770] Ch 51]
[Prior to 2/11/87, Human Services[498]]

441—51.1(249) Application for other benefits. An applicant or any other person whose needs are included in determining the state supplementary assistance payment must have applied for or be receiving all other benefits, including supplemental security income or the family investment program, for which the person may be eligible. The person must cooperate in the eligibility procedures while making application for the other benefits. Failure to cooperate shall result in ineligibility for state supplementary assistance.

This rule is intended to implement Iowa Code section 249.3.

441—51.2(249) Supplementation. Any supplemental payment made on behalf of the recipient from any source other than a nonfederal governmental entity shall be considered as income, and the payment shall be used to reduce the state supplementary assistance payment.

441—51.3(249) Eligibility for residential care.

51.3(1) *Licensed facility.* Payment for residential care shall be made only when the facility in which the applicant or recipient is residing is currently licensed by the department of inspections and appeals pursuant to laws governing health care facilities.

51.3(2) *Physician's statement.* Payment for residential care shall be made only when there is on file an order written by a physician certifying that the applicant or recipient being admitted requires residential care but does not require nursing services. The certification shall be updated whenever a change in the recipient's physical condition warrants reevaluation, but no less than every 12 months.

51.3(3) *Income eligibility.* The resident shall be income eligible when the income according to 52.1(3)*"a"* is less than 31 times the per diem rate of the facility. Partners in a marriage who both enter the same room of the residential care facility in the same month shall be income eligible for the initial month when their combined income according to 52.1(3)*"a"* is less than twice the amount of allowed income for one person (31 times the per diem rate of the facility).

51.3(4) *Diversion of income.* Rescinded IAB 5/1/91, effective 7/1/91.

51.3(5) *Resources.* Rescinded IAB 5/1/91, effective 7/1/91.

This rule is intended to implement Iowa Code section 249.3.

441—51.4(249) Dependent relatives.

51.4(1) *Income.* Income of a dependent relative shall be less than $357. When the dependent's income is from earnings, an exemption of $65 shall be allowed to cover work expense.

51.4(2) *Resources.* The resource limitation for a recipient and a dependent child or parent shall be $2,000. The resource limitation for a recipient and a dependent spouse shall be $3,000. The resource limitation for a recipient, spouse, and dependent child or parent shall be $3,000.

51.4(3) *Living in the home.* A dependent relative shall be eligible until out of the recipient's home for a full calendar month starting at 12:01 a.m. on the first day of the month until 12 midnight on the last day of the same month.

51.4(4) *Dependency.* A dependent relative may be the recipient's ineligible spouse, parent, child, or adult child who is financially dependent upon the recipient. A relative shall not be considered to be financially dependent upon the recipient when the relative is living with a spouse who is not the recipient.

This rule is intended to implement Iowa Code sections 249.3 and 249.4.

[**ARC 7605B**, IAB 3/11/09, effective 4/15/09; **ARC 9965B**, IAB 1/11/12, effective 1/1/12; **ARC 0064C**, IAB 4/4/12, effective 5/9/12]

441—51.5(249) Residence. A recipient of state supplementary assistance shall be living in the state of Iowa.

This rule is intended to implement Iowa Code section 249.3.

441—51.6(249) Eligibility for supplement for Medicare and Medicaid eligibles. The following eligibility requirements are specific to the supplement for Medicare and Medicaid eligibles:

51.6(1) *Medicaid eligibility.* The recipient must be eligible for and receiving full medical assistance benefits under Iowa Code chapter 249A without regard to eligibility based on receipt of state supplementary assistance under this rule, and without being required to meet a spenddown or pay a premium to be eligible for medical assistance benefits.

51.6(2) *SSI eligibility.* The recipient shall meet all eligibility requirements for supplemental security income benefits other than limits on substantial gainful activity and income.

51.6(3) *Not otherwise eligible.* The recipient must not be eligible for benefits under another state supplementary assistance group.

51.6(4) *Medicare eligibility.* The recipient must be currently eligible for Medicare Part B.

51.6(5) *Living arrangement.* A recipient may live in one of the following:

a. The person's own home.

b. The home of another person.

c. A group living arrangement.

d. A medical facility.

51.6(6) *Income.* Income of a recipient shall be within the income limit for the person's Medicaid eligibility group, but must exceed 120 percent of the federal poverty level.

This rule is intended to implement Iowa Code section 249.3 as amended by 2005 Iowa Acts, House File 825, section 108.

441—51.7(249) Income from providing room and board. In determining profit from furnishing room and board or providing family life home care, $357 per month shall be deducted to cover the cost, and the remaining amount treated as earned income.

This rule is intended to implement Iowa Code sections 249.3 and 249.4.

[**ARC 7605B**, IAB 3/11/09, effective 4/15/09; **ARC 9965B**, IAB 1/11/12, effective 1/1/12; **ARC 0064C**, IAB 4/4/12, effective 5/9/12]

441—51.8(249) Furnishing of social security number. As a condition of eligibility applicants or recipients of state supplementary assistance must furnish their social security account numbers or proof of application for the numbers if they have not been issued or are not known and provide their numbers upon receipt.

Assistance shall not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicants or recipients are cooperating in providing information necessary for issuance of their social security numbers.

This rule is intended to implement Iowa Code sections 249.3 and 249.4.

441—51.9(249) Recovery.

51.9(1) *Definitions.*

"Administrative overpayment" means assistance incorrectly paid to or for the client because of continuing assistance during the appeal process.

"Agency error" means assistance incorrectly paid to or for the client because of action attributed to the department as the result of one or more of the following circumstances:

1. Misfiling or loss of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.
5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the local office.
6. Failure to make prompt revisions in payment following changes in policies requiring the changes as of a specific date.

"Client" means a current or former applicant or recipient of state supplementary assistance.

"Client error" means assistance incorrectly paid to or for the client because the client or client's representative failed to disclose information, or gave false or misleading statements, oral or written, regarding the client's income, resources, or other eligibility and benefit factors. It also means assistance incorrectly paid to or for the client because of failure by the client or client's representative to timely report as defined in rule 441—76.10(249A).

"Department" means the department of human services.

51.9(2) *Amount subject to recovery.* The department shall recover from a client all state supplementary assistance funds incorrectly expended to or on behalf of the client, or when conditional benefits have been granted.

a. The department also shall seek to recover the state supplementary assistance granted during the period of time that conditional benefits were correctly granted the client under the policies of the supplemental security income program.

b. The incorrect expenditures may result from client or agency error, or administrative overpayment.

51.9(3) *Notification.* All clients shall be promptly notified when it is determined that assistance was incorrectly expended. Notification shall include for whom assistance was paid; the time period during which assistance was incorrectly paid; the amount of assistance subject to recovery, when known; and the reason for the incorrect expenditure.

51.9(4) *Source of recovery.* Recovery shall be made from the client or from parents of children under the age of 21 when the parents completed the application and had responsibility for reporting changes. Recovery must come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

51.9(5) *Repayment.* The repayment of incorrectly expended state supplementary assistance funds shall be made to the department.

51.9(6) *Appeals.* The client shall have the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 7.

This rule is intended to implement Iowa Code sections 249.3 and 249.4.

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CHAPTER 52
PAYMENT

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

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

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

$765	Care allowance
$ 95	Personal allowance
$860	Total

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

a. Aged or disabled client and a dependent relative $1,055
b. Aged or disabled client, eligible spouse, and a dependent relative $1,405
c. Blind client and a dependent relative $1,077
d. Blind client, aged or disabled spouse, and a dependent relative $1,427
e. Blind client, blind spouse, and a dependent relative $1,449

52.1(3) *Residential care.* Payment to a recipient in a residential care facility shall be made on a flat per diem rate of $17.86 or on a cost-related reimbursement system with a maximum per diem rate of $28.92. The department shall establish a cost-related per diem rate for each facility choosing this method of payment according to rule 441—54.3(249).

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

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

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

(1) When income is earned, impairment related work expenses, as defined by SSI plus $65 plus one-half of any remaining earned income.

(2) An allowance of $95 to meet personal expenses and Medicaid copayment expenses.

(3) When there is a spouse at home, the amount of the SSI benefit for an individual minus the spouse's countable income according to SSI policies. When the spouse at home has been determined eligible for SSI benefits, no income disregard shall be made.

(4) When there is a dependent child living with the spouse at home who meets the definition of a dependent according to the SSI program, the amount of the SSI allowance for a dependent minus the dependent's countable income and the amount of income from the parent at home that exceeds the SSI benefit for one according to SSI policies.

(5) Established unmet medical needs of the resident, excluding private health insurance premiums and Medicaid copayment expenses. Unmet medical needs of the spouse at home, exclusive of health insurance premiums and Medicaid copayment expenses, shall be an additional deduction when the countable income of the spouse at home is not sufficient to cover those expenses. Unmet medical needs of the dependent living with the spouse at home, exclusive of health insurance premiums and Medicaid copayment expenses, shall also be deducted when the countable income of the dependent and the income of the parent at home that exceeds the SSI benefit for one is not sufficient to cover the expenses.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This rule is intended to implement Iowa Code chapter 249.

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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, therapeutically certified 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. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the state department of public health. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid.

b. Routine physical examinations. Rescinded IAB 8/1/07, effective 8/1/07.

c. Treatment of certain foot conditions as specified in 78.5(2)*"a," "b,"* and *"c."*

d. Acupuncture treatments.

e. Rescinded 9/6/78.

f. Unproven or experimental medical and surgical procedures. The criteria in effect in the Medicare program shall be utilized in determining when a given procedure is unproven or experimental in nature.

g. Charges for surgical procedures on the "Outpatient/Same Day Surgery List" produced by the Iowa Foundation for Medical Care or associated inpatient care charges when the procedure is performed in a hospital on an inpatient basis unless the physician has secured approval from the hospital's utilization review department prior to the patient's admittance to the hospital. Approval shall be granted only when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The "Outpatient/Same Day Surgery List" shall be published by the department in the provider manuals for hospitals and physicians. The "Outpatient/Same Day Surgery List" shall be developed by the Iowa Foundation for Medical Care, and shall include procedures which can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. The Iowa Foundation for Medical Care may add, delete, or modify entries on the "Outpatient/Same Day Surgery List."

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 78.15(249A).

78.1(7) No payment shall be made for the services of a private duty nurse.

78.1(8) Payment for mileage shall be the same as that in effect in part B of Medicare.

78.1(9) Payment will be approved for visits to patients in nursing facilities subject to the following conditions:

a. Payment will be approved for only one visit to the same patient in a calendar month. Payment for further visits will be made only when the need for the visits is adequately documented by the physician.

b. When only one patient is seen in a single visit the allowance shall be based on a follow-up home visit. When more than one patient is seen in a single visit, payment shall be based on a follow-up office visit. In the absence of information on the claim, the carrier will assume that more than one patient was seen, and payment approved on that basis.

c. Payment will be approved for mileage in connection with nursing home visits when:

(1) It is necessary for the physician to travel outside the home community, and

(2) There are not physicians in the community in which the nursing home is located.

d. Payment will be approved for tasks related to a resident receiving nursing facility care which are performed by a physician's employee who is a nurse practitioner, clinical nurse specialist, or physician assistant as specified in 441—paragraph 81.13(13)*"e."* On-site supervision of the physician is not required for these services.

78.1(10) Payment will be approved in independent laboratory when it has been certified as eligible to participate in Medicare.

78.1(11) Rescinded, effective 8/1/87.

78.1(12) Payment will be made on the same basis as in Medicare for services associated with treatment of chronic renal disease including physician's services, hospital care, renal transplantation, and hemodialysis, whether performed on an inpatient or outpatient basis. Payment will be made for deductibles and coinsurance for those persons eligible for Medicare.

78.1(13) Payment will be made to the physician for services rendered by auxiliary personnel employed by the physician and working under the direct personal supervision of the physician, when such services are performed incident to the physician's professional service.

a. Auxiliary personnel are nurses, physician's assistants, psychologists, social workers, audiologists, occupational therapists and physical therapists.

b. An auxiliary person is considered to be an employee of the physician if the physician:

(1) Is able to control the manner in which the work is performed, i.e., is able to control when, where and how the work is done. This control need not be actually exercised by the physician.

(2) Sets work standards.

(3) Establishes job description.

(4) Withholds taxes from the wages of the auxiliary personnel.

c. Direct personal supervision in the office setting means the physician must be present in the same office suite, not necessarily the same room, and be available to provide immediate assistance and direction.

Direct personal supervision outside the office setting, such as the member's home, hospital, emergency room, or nursing facility, means the physician must be present in the same room as the auxiliary person.

Advanced registered nurse practitioners certified under board of nursing rules 655—Chapter 7 performing services within their scope of practice are exempt from the direct personal supervision requirement for the purpose of reimbursement to the employing physicians. In these exempted circumstances, the employing physicians must still provide general supervision and be available to provide immediate needed assistance by telephone. Advanced registered nurse practitioners who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

A physician assistant licensed under board of physician assistants' professional licensure rules in 645—Chapter 325 is exempt from the direct personal supervision requirement but the physician must still provide general supervision and be available to provide immediate needed assistance by telephone. Physician assistants who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician's professional service to the member. If the physician

has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

78.1(14) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a physician for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.1(15) The certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance record is sufficient for the original certification.

78.1(16) No payment will be made for sterilization of an individual under the age of 21 or who is mentally incompetent or institutionalized. Payment will be made for sterilization performed on an individual who is aged 21 or older at the time the informed consent is obtained and who is mentally competent and not institutionalized when all the conditions in this subrule are met.

a. The following definitions are pertinent to this subrule:

(1) Sterilization means any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing and which is not a necessary part of the treatment of an existing illness or medically indicated as an accompaniment of an operation on the genital urinary tract. Mental illness or retardation is not considered an illness or injury.

(2) Hysterectomy means a medical procedure or operation to remove the uterus.

(3) Mentally incompetent individual means a person who has been declared mentally incompetent by a federal, state or local court of jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

(4) Institutionalized individual means an individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or an individual who is confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

b. The sterilization shall be performed as the result of a voluntary request for the services made by the person on whom the sterilization is performed. The person's consent for sterilization shall be documented on:

(1) Form 470-0835 or 470-0835(S), Consent Form, or

(2) An official sterilization consent form from another state's Medicaid program that contains all information found on the Iowa form and complies with all applicable federal regulations.

c. The person shall be advised prior to the receipt of consent that no benefits provided under the medical assistance program or other programs administered by the department may be withdrawn or withheld by reason of a decision not to be sterilized.

d. The person shall be informed that the consent can be withheld or withdrawn any time prior to the sterilization without prejudicing future care and without loss of other project or program benefits.

e. The person shall be given a complete explanation of the sterilization. The explanation shall include:

(1) A description of available alternative methods and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure.

(2) A thorough description of the specific sterilization procedure to be performed and benefits expected.

(3) A description of the attendant discomforts and risks including the type and possible effects of any anesthetic to be used.

(4) An offer to answer any inquiries the person to be sterilized may have concerning the procedure to be performed. The individual shall be provided a copy of the informed consent form in addition to the oral presentation.

f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent except in the case of premature delivery or emergency abdominal surgery which occurs

not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

g. The information in paragraphs *"b"* through *"f"* shall be effectively presented to a blind, deaf, or otherwise handicapped individual and an interpreter shall be provided when the individual to be sterilized does not understand the language used on the consent form or used by the person obtaining consent. The individual to be sterilized may have a witness of the individual's choice present when consent is obtained.

h. The consent form described in paragraph 78.1(16)*"b"* shall be attached to the claim for payment and shall be signed by:

(1) The person to be sterilized,

(2) The interpreter, when one was necessary,

(3) The physician, and

(4) The person who provided the required information.

i. Informed consent shall not be obtained while the individual to be sterilized is:

(1) In labor or childbirth, or

(2) Seeking to obtain or obtaining an abortion, or

(3) Under the influence of alcohol or other substance that affects the individual's state of awareness.

j. Payment will be made for a medically necessary hysterectomy only when it is performed for a purpose other than sterilization and only when one or more of the following conditions is met:

(1) The individual or representative has signed an acknowledgment that she has been informed orally and in writing from the person authorized to perform the hysterectomy that the hysterectomy will make the individual permanently incapable of reproducing, or

(2) The individual was already sterile before the hysterectomy, the physician has certified in writing that the individual was already sterile at the time of the hysterectomy and has stated the cause of the sterility, or

(3) The hysterectomy was performed as a result of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible and the physician includes a description of the nature of the emergency.

78.1(17) Abortions. Payment for an abortion or related service is made when Form 470-0836 is completed for the applicable circumstances and is attached to each claim for services. Payment for an abortion is made under one of the following circumstances:

a. The physician certifies that the pregnant woman's life would be endangered if the fetus were carried to term.

b. The physician certifies that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and the physician states the medical indication for determining the fetal condition.

c. The pregnancy was the result of rape reported to a law enforcement agency or public or private health agency which may include a family physician within 45 days of the date of occurrence of the incident. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of the rape.

d. The pregnancy was the result of incest reported to a law enforcement agency or public or private health agency including a family physician no later than 150 days after the date of occurrence. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of incest.

78.1(18) Payment and procedure for obtaining eyeglasses, contact lenses, and visual aids, shall be the same as described in 441—78.6(249A). (Cross-reference 78.28(3))

78.1(19) Preprocedure review by the Iowa Foundation for Medical Care (IFMC) will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the published criteria established by the IFMC and the department. If not so approved by the IFMC, payment will not be made under the program to the physician or to the facility

in which the surgery is performed. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

The "Preprocedure Surgical Review List" shall be published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. The "Preprocedure Surgical Review List" shall be developed by the department with advice and consultation from the IFMC and appropriate professional organizations and will list the procedures for which prior review is required and the steps that must be followed in requesting such review. The department shall update the "Preprocedure Surgical Review List" annually. (Cross-reference 78.28(1)*"e."*)

78.1(20) Transplants.

a. Payment will be made only for the following organ and tissue transplant services:

(1) Kidney, cornea, skin, and bone transplants.

(2) Allogeneic bone marrow transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease, Wiskott-Aldrich syndrome, or the following types of leukemia: acute myelocytic leukemia in relapse or remission, chronic myelogenous leukemia, and acute lemphocytic leukemia in remission.

(3) Autologous bone marrow transplants for treatment of the following conditions: acute leukemia in remission with a high probability of relapse when there is no matched donor; resistant non-Hodgkin's lymphomas; lymphomas presenting poor prognostic features; recurrent or refractory neuroblastoma; or advanced Hodgkin's disease when conventional therapy has failed and there is no matched donor.

(4) Liver transplants for persons with extrahepatic biliary artesia or any other form of end-stage liver disease, except that coverage is not provided for persons with a malignancy extending beyond the margins of the liver.

Liver transplants require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1)*"f."*)

Covered liver transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(5) Heart transplants. Artificial hearts and ventricular assist devices, either as a permanent replacement for a human heart or as a temporary life-support system until a human heart becomes available for transplants, are not covered. Heart-lung transplants are covered where bilateral or unilateral lung transplantation with repair of a congenital cardiac defect is contraindicated.

Heart transplants and heart-lung transplants described above require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1)*"f."*) Covered heart transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(6) Lung transplants. Lung transplants for persons having end-stage pulmonary disease. Lung transplants require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1)*"f."*) Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10). Heart-lung transplants are covered consistent with criteria in subparagraph (5) above.

(7) Pancreas transplants for persons with type I diabetes mellitus, as follows:

1. Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.
2. Pancreas transplants alone are covered for persons exhibiting any of the following:

- A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.
- Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.
- Consistent failure of insulin-based management to prevent acute complications.

The pancreas transplants listed under this subparagraph require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1)*"f."*)

Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

Transplantation of islet cells or partial pancreatic tissue is not covered.

b. Donor expenses incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery. Expenses of searching for a donor are not covered.

c. All transplants must be medically necessary and meet other general requirements of this chapter for physician and hospital services.

d. Payment will not be made for any transplant not specifically listed in paragraph *"a."*

78.1(21) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. For the purposes of utilization review, the term "physician" does not include a psychiatrist. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.1(22) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. Enhanced services include health education, social services, nutrition education, and a postpartum home visit. Additional reimbursement shall be provided for obstetrical services related to a high-risk pregnancy. (See description of enhanced services at subrule 78.25(3).)

78.1(23) EPSDT care coordination. Rescinded IAB 12/3/08, effective 2/1/09.

78.1(24) Topical fluoride varnish. Payment shall be made for application of an FDA-approved topical fluoride varnish, as defined by the Current Dental Terminology, Third Edition (CDT-3), for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:

a. Application of topical fluoride varnish must be provided in conjunction with an early and periodic screening, diagnosis, and treatment (EPSDT) examination which includes a limited oral screening.

b. Separate payment shall be available only for application of topical fluoride varnish, which shall be at the same rate of reimbursement paid to dentists for providing this service. Separate payment for the limited oral screening shall not be available, as this service is already part of and paid under the EPSDT screening examination.

c. Parents, legal guardians, or other authorized caregivers of children receiving application of topical fluoride varnish as part of an EPSDT screening examination shall be informed by the physician or auxiliary staff employed by and under the physician's supervision that this application is not a substitute for comprehensive dental care.

d. Physicians rendering the services under this subrule shall make every reasonable effort to refer or facilitate referral of these children for comprehensive dental care rendered by a dental professional.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 8714B**, IAB 5/5/10, effective 5/1/10; **ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.2(249A) Prescribed outpatient drugs. Payment will be made for "covered outpatient drugs" as defined in 42 U.S.C. Section 1396r-8(k)(2)-(4) subject to the conditions and limitations specified in this rule.

78.2(1) *Qualified prescriber.* All drugs are covered only if prescribed by a legally qualified practitioner (physician, dentist, podiatrist, therapeutically certified optometrist, physician assistant, or advanced registered nurse practitioner).

78.2(2) *Prescription required.* As a condition of payment for all drugs, including "nonprescription" or "over-the-counter" drugs that may otherwise be dispensed without a prescription, a prescription shall be transmitted as specified in Iowa Code sections 124.308 and 155A.27, subject to the provisions of Iowa Code section 155A.29 regarding refills. All prescriptions shall be available for audit by the department.

78.2(3) *Qualified source.* All drugs are covered only if marketed by manufacturers that have signed a Medicaid rebate agreement with the Secretary of Health and Human Services in accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990).

78.2(4) *Prescription drugs.* Drugs that may be dispensed only upon a prescription are covered subject to the following limitations.

a. Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A as amended by 2010 Iowa Acts, Senate File 2088, section 347.

(1) For any drug requiring prior authorization, reimbursement will be made for a 72-hour or three-day supply dispensed in an emergency when a prior authorization request cannot be submitted.

(2) Unless the manufacturer or labeler of a mental health prescription drug that has a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class enters into a contract to provide the state with a supplemental rebate, the drug may be placed on the preferred drug list as nonpreferred, with prior authorization required. However, prior authorization shall not be required for such a drug for a member whose regimen on the drug was established before January 1, 2011, as verified by documented pharmacy claims.

(3) For mental health prescription drugs requiring prior authorization that have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class, reimbursement will be made for up to a seven-day supply pending prior authorization. A request for prior authorization shall be deemed approved if the prescriber:

1. Has on file with the department current contact information, including a current fax number, and a signed Form 470-4914, Fax Confidentiality Certificate, and

2. Does not receive a notice of approval or disapproval within 48 hours of a request for prior authorization.

b. Payment is not made for:

(1) Drugs whose prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act.

(2) Drugs used for anorexia, weight gain, or weight loss.

(3) Drugs used for cosmetic purposes or hair growth.

(4) Rescinded IAB 2/8/12, effective 3/14/12.

(5) Otherwise covered outpatient drugs if the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer's designee.

(6) Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations (drugs identified through the Drug Efficacy Study Implementation (DESI) review)).

(7) "Covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any "Part D eligible individual" as defined by 42 U.S.C. Section 1395w-101(a)(3)(A), including a member who is not enrolled in a Medicare Part D plan.

(8) Drugs prescribed for fertility purposes, except when prescribed for a medically accepted indication other than infertility, as defined in subparagraph (1).

(9) Drugs used for the treatment of sexual or erectile dysfunction, except when used to treat a condition other than sexual or erectile dysfunction for which the drug has been approved by the U.S. Food and Drug Administration.

(10) Prescription drugs for which the prescription was executed in written (and nonelectronic) form unless the prescription was executed on a tamper-resistant pad, as required by Section 1903(i)(23) of the Social Security Act (42 U.S.C. Section 1396b(i)(23)).

(11) Drugs used for symptomatic relief of cough and colds, except for nonprescription drugs listed at subrule 78.2(5).

78.2(5) *Nonprescription drugs.* The following drugs that may otherwise be dispensed without a prescription are covered subject to the prior authorization requirements stated below and as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

Acetaminophen tablets 325 mg, 500 mg

Acetaminophen elixir 160 mg/5 ml
Acetaminophen solution 100 mg/ml
Acetaminophen suppositories 120 mg
Artificial tears ophthalmic solution
Artificial tears ophthalmic ointment
Aspirin tablets 325 mg, 650 mg, 81 mg (chewable)
Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg
Aspirin tablets, buffered 325 mg
Bacitracin ointment 500 units/gm
Benzoyl peroxide 5%, gel, lotion
Benzoyl peroxide 10%, gel, lotion
Calcium carbonate chewable tablets 500 mg, 750 mg, 1000 mg, 1250 mg
Calcium carbonate suspension 1250 mg/5 ml
Calcium carbonate tablets 600 mg
Calcium carbonate-vitamin D tablets 500 mg-200 units
Calcium carbonate-vitamin D tablets 600 mg-200 units
Calcium citrate tablets 950 mg (200 mg elemental calcium)
Calcium gluconate tablets 650 mg
Calcium lactate tablets 650 mg
Cetirizine hydrochloride liquid 1 mg/ml
Cetirizine hydrochloride tablets 5 mg
Cetirizine hydrochloride tablets 10 mg
Chlorpheniramine maleate tablets 4 mg
Clotrimazole vaginal cream 1%
Diphenhydramine hydrochloride capsules 25 mg
Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml
Epinephrine racemic solution 2.25%
Ferrous sulfate tablets 325 mg
Ferrous sulfate elixir 220 mg/5 ml
Ferrous sulfate drops 75 mg/0.6 ml
Ferrous gluconate tablets 325 mg
Ferrous fumarate tablets 325 mg
Guaifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid
Ibuprofen suspension 100 mg/5 ml
Ibuprofen tablets 200 mg
Insulin
Lactic acid (ammonium lactate) lotion 12%
Loperamide hydrochloride liquid 1 mg/5 ml
Loperamide hydrochloride tablets 2 mg
Loratadine syrup 5 mg/5 ml
Loratadine tablets 10 mg
Magnesium hydroxide suspension 400 mg/5 ml
Magnesium oxide capsule 140 mg (85 mg elemental magnesium)
Magnesium oxide tablets 400 mg
Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
Miconazole nitrate cream 2% topical and vaginal
Miconazole nitrate vaginal suppositories, 100 mg
Multiple vitamin and mineral products with prior authorization
Neomycin-bacitracin-polymyxin ointment
Niacin (nicotinic acid) tablets 50 mg, 100 mg, 250 mg, 500 mg
Nicotine gum 2 mg, 4 mg
Nicotine lozenge 2 mg, 4 mg

Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
Pediatric oral electrolyte solutions
Permethrin lotion 1%
Polyethylene glycol 3350 powder
Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
Pseudoephedrine hydrochloride liquid 30 mg/5 ml
Pyrethrins-piperonyl butoxide liquid 0.33-4%
Pyrethrins-piperonyl butoxide shampoo 0.3-3%
Pyrethrins-piperonyl butoxide shampoo 0.33-4%
Salicylic acid liquid 17%
Senna tablets 187 mg
Sennosides-docusate sodium tablets 8.6 mg-50 mg
Sennosides syrup 8.8 mg/5 ml
Sennosides tablets 8.6 mg
Sodium bicarbonate tablets 325 mg
Sodium bicarbonate tablets 650 mg
Sodium chloride hypertonic ophthalmic ointment 5%
Sodium chloride hypertonic ophthalmic solution 5%
Tolnaftate 1% cream, solution, powder

Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

78.2(6) *Quantity prescribed and dispensed.*

a. When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe a quantity of prescription medication sufficient for up to a 31-day supply. Oral contraceptives may be prescribed in 90-day quantities.

b. Oral solid forms of covered nonprescription items shall be prescribed and dispensed in a minimum quantity of 100 units per prescription or the currently available consumer package size except when dispensed via a unit-dose system.

78.2(7) *Lowest cost item.* The pharmacist shall dispense the lowest cost item in stock that meets the requirements of the practitioner as shown on the prescription.

78.2(8) *Consultation.* In accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990), a pharmacist shall offer to discuss information regarding the use of the medication with each Medicaid member or the caregiver of a member presenting a prescription. The consultation is not required if the person refuses the consultation. Standards for the content of the consultation shall be found in rules of the Iowa board of pharmacy.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 8097B**, IAB 9/9/09, effective 11/1/09; **ARC 9175B**, IAB 11/3/10, effective 1/1/11; **ARC 9699B**, IAB 9/7/11, effective 9/1/11; **ARC 9834B**, IAB 11/2/11, effective 11/1/11; **ARC 9882B**, IAB 11/30/11, effective 1/4/12; **ARC 9981B**, IAB 2/8/12, effective 3/14/12]

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 Foundation for Medical Care (IFMC). 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. Readmissions to the same facility due to premature discharge shall not be paid a new DRG. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. (Cross-reference 78.28(5)) The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. No payment will be made for waiver days.

See rule 441—78.31(249A) for policies regarding payment of hospital outpatient services.

If the recipient is eligible for inpatient or outpatient hospital care through the Medicare program, payment will be made for deductibles and coinsurance as set out in 441—subrule 79.1(22).

The DRG payment calculations include any special services required by the hospital, including a private room.

78.3(1) Payment for Medicaid-certified physical rehabilitation units will be approved for the day of admission but not the day of discharge or death.

78.3(2) No payment will be approved for private duty nursing.

78.3(3) Certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance records are sufficient for the original certification.

78.3(4) Services provided for intestinal or gastric bypass surgery for treatment of obesity requires prior approval, which must be obtained by the attending physician before surgery is performed.

78.3(5) Payment will be approved for drugs provided inpatients subject to the same provisions specified in 78.2(1) and 78.2(4)*"b"*(1) to (10) except for 78.2(4)*"b"*(7). The basis of payment for drugs administered to inpatients is through the DRG reimbursement.

a. Payment will be approved for drugs and supplies provided outpatients subject to the same provisions specified in 78.2(1) through 78.2(4) except for 78.2(4)*"b"*(7). The basis of payment for drugs provided outpatients is through a combination of Medicaid-determined fee schedules and ambulatory payment classification, pursuant to 441—subrule 79.1(16).

b. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.3(6) Payment for nursing care provided by a hospital shall be made to those hospitals which have been certified by the department of inspections and appeals as meeting the standards for a nursing facility.

78.3(7) Payment for inpatient hospital tests for purposes of diagnosis and treatment shall be made only when the tests are specifically ordered for the diagnosis and treatment of a particular patient's condition by the attending physician or other licensed practitioner acting within the scope of practice as defined by law, who is responsible for that patient's diagnosis or treatment.

78.3(8) Rescinded IAB 2/6/91, effective 4/1/91.

78.3(9) Payment will be made for sterilizations in accordance with 78.1(16).

78.3(10) Payment will be approved for organ and tissue transplant services, as specified in subrule 78.1(20). Kidney, cornea, skin, bone, allogeneic bone marrow, autologous bone marrow, heart, liver, and lung transplants are covered as specified in subrule 78.1(20). Lung transplants are payable at Medicare-designated lung transplant centers only. Heart and liver transplants are payable when performed at facilities that meet the following criteria:

a. Recipient selection and education.

(1) *Selection.* The transplant center must have written criteria based on medical need for transplantation for final facility selection of recipients. These criteria should include an equitable, consistent and practical protocol for selection of recipients. The criteria must be at least as strict as those specified by Medicare.

(2) *Education.* The transplant center will provide a written plan for recipient education. It shall include educational plans for recipient, family and significant others during all phases of the program. These phases shall include:

Intake.

Preparation and waiting period.

Preadmission.

Hospitalization.

Discharge planning.

Follow-up.

b. Staffing and resource commitment.

(1) *Transplant surgeon.* The transplant center must have on staff a qualified transplant surgeon.

The surgeon must have received at least one year of training at a transplant center approved by the American Society of Transplant Surgeons under the direction of an experienced transplant surgeon and

must have had at least two years of experience in all facets of transplant surgery specific to the surgeon's specialty. This experience must include management of recipients' presurgical and postsurgical care and actual experience as a member of a transplant team at the institution. The transplant surgeon will have an understanding of the principles of and demonstrated expertise in the use of immunosuppressive therapy.

The transplant surgeon will be certified by the American Board of Thoracic Surgery or equivalent for heart transplants and the American Board of Surgery or equivalent for liver transplants.

The transplant surgeon will be the defined leader of a stable, established transplant team that has a strong commitment to the transplant program.

(2) *Transplant team.* The transplant team will be clearly defined with leadership and corresponding responsibilities of all team members identified.

The team should consist of:

A surgeon director.

A board-certified internist or pediatrician with training and expertise in organ transplantation medicine and clinical use of immunosuppressive regimens.

The transplant center will assume responsibility for initial training and continuing education of the transplant team and ancillary personnel. The center will maintain records that demonstrate competency in achieving, maintaining and improving skills in the distinct areas of expertise of each of the team members.

(3) *Physicians.* The transplant center will have on staff or available for consultation physicians with the following areas of expertise:

Anesthesiology.

Cardiology.

Dialysis.

Gastroenterology.

Hepatology.

Immunology.

Infectious diseases.

Nephrology.

Neurology.

Pathology.

Pediatrics.

Psychiatry.

Pulmonary medicine.

Radiology.

Rehabilitation medicine.

Liaison with the recipient's permanent physician is established for the purpose of providing continuity and management of the recipient's long-term care.

(4) *Support personnel and resources.* The center must have a commitment of sufficient resources and planning for implementation and operation of the transplant program. Indicators of the commitment will include the following:

Persons with expertise in the following areas available at the transplant center:

Anesthesiology.

Blood bank services.

Cardiology.

Cardiovascular surgery.

Dialysis.

Dietary services.

Gastroenterology.

Infection control.

Laboratory services (pathology, microbiology, immunology, tissue typing, and monitoring of immunosuppressive drugs).

Legal counsel familiar with transplantation laws and regulations.

Nursing service department with staff available who have expertise in the care of transplant recipients, especially in managing immunosuppressed patients and hemodynamic support.

Respiratory therapy.

Pharmaceutical services.

Physical therapy.

Psychiatry.

Psycho-social.

The center will have active cardiovascular, medical, and surgical programs with the ability and willingness to perform diagnostic and evaluative procedures appropriate to transplants on an emergency and ongoing basis.

The center will have designated an adequate number of intensive care and general service beds to support the transplant center.

(5) *Laboratory.* Each transplant center must have direct local 24-hour per day access to histocompatibility testing facilities. These facilities must meet the Standards for Histocompatibility Testing set forth by the Committee on Quality Assurance and Standards of the American Society for Histocompatibility and Immunogenetics (ASHI). As specified by ASHI, the director of the facility shall hold a doctoral degree in biological science, or be a physician, and subsequent to graduation shall have had four years' experience in immunology, two of which were devoted to formal training in human histocompatibility testing, documented to be professionally competent by external measures such as national proficiency testing, participation in national or international workshops or publications in peer-reviewed journals. The laboratory must successfully participate in a regional or national testing program.

c. Experience and survival rates.

(1) *Experience.* Centers will be given a minimum volume requirement of 12 heart or 12 liver transplants that should be met within one year. Due to special considerations such as patient case mix or donor availability, an additional one year conditional approval may be given if the minimum volume is not met the first year.

For approval of an extrarenal organ transplant program it is highly desirable that the institution: 1. has available a complete team of surgeons, physicians, and other specialists with specific experience in transplantation of that organ, or 2. has an established approved renal transplant program at that institution and personnel with expertise in the extrarenal organ system itself.

(2) *Survival rates.* The transplant center will achieve a record of acceptable performance consistent with the performance and outcomes at other successful designated transplant centers. The center will collect and maintain recipient and graft survival and complication rates. A level of satisfactory success and safety will be demonstrated with bases for substantial probability of continued performance at an acceptable level.

To encourage a high level of performance, transplant programs must achieve and maintain a minimum one-year patient survival rate of 70 percent for heart transplants and 50 percent for liver transplants.

d. Organ procurement. The transplant center will participate in a nationwide organ procurement and typing network.

Detailed plans must exist for organ procurement yielding viable transplantable organs in reasonable numbers, meeting established legal and ethical criteria.

The transplant center must be a member of the National Organ Procurement and Transplant Network.

e. Maintenance of data, research, review and evaluation.

(1) *Maintenance of data.* The transplant center will collect and maintain data on the following:

Risk and benefit.

Morbidity and mortality.

Long-term survival.

Quality of life.

Recipient demographic information.

These data should be maintained in the computer at the transplant center monthly.

The transplant center will submit the above data to the United Network of Organ Sharing yearly.

(2) *Research.* The transplant center will have a plan for and a commitment to research.

Ongoing research regarding the transplanted organs is required.

The transplant center will have a program in graduate medical education or have a formal agreement with a teaching institution for affiliation with a graduate medical education program.

(3) *Review and evaluation.* The transplant center will have a plan for ongoing evaluation of the transplantation program.

The transplant center will have a detailed plan for review and evaluation of recipient selection, preoperative, operative, postoperative and long-term management of the recipient.

The transplant center will conduct concurrent ongoing studies to ensure high quality services are provided in the transplantation program.

The transplant center will provide information to members of the transplant team and ancillary staff regarding the findings of the quality assurance studies. This information will be utilized to provide education geared toward interventions to improve staff performance and reduce complications occurring in the transplant process.

The transplant center will maintain records of all quality assurance and peer review activities concerning the transplantation program to document identification of problems or potential problems, intervention, education and follow-up.

f. Application procedure. A Medicare-designated heart, liver, or lung transplant facility needs only to submit evidence of this designation to the Iowa Medicaid enterprise provider services unit. The application procedure for other heart and liver facilities is as follows:

(1) An original and two copies of the application must be submitted on 8½ by 11 inch paper, signed by a person authorized to do so. The facility must be a participating hospital under Medicaid and must specify its provider number, and the name and telephone number of a contact person should there be questions regarding the application.

(2) Information and data must be clearly stated, well organized and appropriately indexed to aid in its review against the criteria specified in this rule. Each page must be numbered.

(3) To the extent possible, the application should be organized into five sections corresponding to each of the five major criteria and addressing, in order, each of the subcriteria identified.

(4) The application should be mailed to the Iowa Medicaid enterprise provider services unit.

g. Review and approval of facilities. An organized review committee will be established to evaluate performance and survival statistics and make recommendations regarding approval as a designated transplant center based on acceptable performance standards established by the review organization and approved by the Medicaid agency.

There will be established protocol for the systematic evaluation of patient outcome including survival statistics.

Once a facility applies for approval and is approved as a heart or liver transplant facility for Medicaid purposes, it is obliged to report immediately to the department any events or changes which would affect its approved status. Specifically, a facility must report any significant decrease in its experience level or survival rates, the transplantation of patients who do not meet its patient selection criteria, the loss of key members of the transplant team, or any other major changes that could affect the performance of heart or liver transplants at the facility. Changes from the terms of approval may lead to withdrawal of approval for Medicaid coverage of heart or liver transplants performed at the facility.

78.3(11) Payment will be approved for inpatient hospital care rendered a patient in connection with dental treatment only when the mental, physical, or emotional condition of the patient prevents the dentist from providing this necessary care in the office.

78.3(12) Payment will be approved for an assessment fee as specified in 441—paragraphs 79.1(16)*"a"* and *"r"* to determine if a medical emergency exists.

Medical emergency is defined as a sudden or unforeseen occurrence or combination of circumstances presenting a substantial risk to an individual's health unless immediate medical treatment is given.

The determination of whether a medical emergency exists will be based on the patient's medical condition including presenting symptoms and medical history prior to treatment or evaluation.

78.3(13) Payment for patients in acute hospital beds who are determined by IFMC to require the skilled nursing care level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(3) plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective *(a)* as of the date of notice by IFMC that the lower level of care is required or *(b)* for the days IFMC determines in an outlier review that the lower level of care was required.

78.3(14) Payment for patients in acute hospital beds who are determined by IFMC to require nursing facility level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(1) plus the non-direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(1), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective *(a)* as of the date of notice by IFMC that the lower level of care is required or *(b)* for the days IFMC determines in an outlier review that the lower level of care was required.

78.3(15) Payment for inpatient hospital charges associated with surgical procedures on the "Outpatient/Same Day Surgery List" produced by the Iowa Foundation for Medical Care shall be made only when attending physician has secured approval from the hospital's utilization review department prior to admittance to the hospital. Approval shall be granted when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The "Outpatient/Same Day Surgery List" shall be published by the department in the provider manuals for hospitals and physicians. The "Outpatient/Same Day Surgery List" shall be developed by the Iowa Foundation for Medical Care, and shall include procedures which can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. The Iowa Foundation for Medical Care may add, delete or modify entries on the "Outpatient/Same Day Surgery List."

78.3(16) 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.

78.3(17) Rescinded IAB 8/9/89, effective 10/1/89.

78.3(18) Preprocedure review by the IFMC is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 78.28(5))

78.3(19) Rescinded IAB 10/8/97, effective 12/1/97.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

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. Payment will also be made for the following dental procedures subject to the exclusions for services to adults 21 years of age and older set forth in subrule 78.4(14):

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 physical or mental disability, 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 in a six-month period except for people who need more frequent applications because of physical or mental disability. (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 disability that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

78.4(2) *Diagnostic services.* Payment shall be made for the following diagnostic services:

a. A comprehensive oral evaluation is payable once per patient per dentist in a three-year period when the patient has not seen that dentist during the three-year period.

b. A periodic oral examination is payable once in a six-month period.

c. A complete mouth radiograph survey consisting of a minimum of 14 periapical films and bite-wing films is a payable service once in a five-year period, except when medically necessary to evaluate development, and to detect anomalies, injuries and diseases. Complete mouth radiograph surveys are not payable under the age of six. A panographic-type radiography with bitewings is considered the same as a complete 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 when requested by the Iowa Medicaid enterprise medical services unit's dental consultant.

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. Two laboratory-fabricated crowns using nonprecious materials, other than stainless steel, are payable per member in a 12-month period. Additional laboratory-fabricated crowns using nonprecious materials, other than stainless steel, are payable when prior authorization has been obtained. Noble metals are payable for crowns when members are allergic to all other restorative materials. Stainless steel crowns are payable when a more conservative procedure would not be serviceable. (Cross-reference 78.28(2)*"e"*)

e. Cast post and core, steel post and composite or amalgam in addition to a crown is 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 restorative procedures:

(1) Amalgam or acrylic buildups are considered part of the preparation for the completed restoration.

(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) A two-surface anterior composite restoration will be payable as a one-surface restoration if it involved the lingual surface.

(6) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, local anesthesia and inhaled 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 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 when prior approval has been received. A request for approval must be accompanied by a plan for treatment, a completed copy of a periodontal probe chart that exhibits pocket depths, history and radiograph(s). Payment for periodontal scaling and root planing will be approved when interproximal and subgingival calculus is evident in X-rays or when justified and documented that curettage, scaling or root planing is required in addition to routine prophylaxis. (Cross-reference 78.28(2)*"a"*(1))

c. Periodontal surgical procedures which include gingivoplasty, osseous surgery, and osseous allograft are payable services when prior approval has been received. A request for approval must be accompanied by a plan for treatment, a completed copy of a periodontal probe chart that exhibits pocket depths, history and radiograph(s). 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 patient has demonstrated reasonable oral hygiene, unless the patient is unable to demonstrate reasonable oral hygiene because of physical or mental disability or in cases which demonstrate gingival hyperplasia resulting from drug therapy. (Cross-reference 78.28(2)*"a"*(2))

d. Pedicle soft tissue graft and free soft tissue graft are payable services with prior approval based on a written narrative describing medical necessity. (Cross-reference 78.28(2)*"a"*(3))

e. Periodontal maintenance therapy which includes oral prophylaxis, measurement of pocket depths and limited root planing and scaling is a payable service when prior approval has been received. A request for approval must be accompanied by a periodontal treatment plan, a completed copy of a periodontal probe chart which exhibits pocket depths, periodontal history and radiograph(s). Payment for periodontal maintenance therapy may be approved after periodontal scaling and root planing or periodontal surgical procedures have been provided. Periodontal maintenance therapy may be approved once per three-month interval for moderate to advanced cases if the condition would deteriorate without treatment. (Cross-reference 78.28(2)*"a"*(4))

f. Payment as indicated will be made for the following periodontal services:

(1) Periodontal scaling and root planing, gingivoplasty, osseous surgery will be paid per quadrant.

(2) Gingivoplasty will be paid per tooth.

(3) Osseous allograft will be paid as a single site if one site is involved, or if more than one site is involved, payment will be made for multiple sites.

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 extensive posttreatment restorative procedures are not necessary and when missing teeth do not jeopardize the integrity or function of the dental arches.

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 is payable when prior approval has been received. Payment for 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 will be

approved when nonsurgical treatment has been attempted and a reasonable time has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

(1) Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross-reference 78.28(2)*"d"*)

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, and failure has been demonstrated with a radiograph and narrative history.

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. General anesthesia, intravenous sedation, and non-intravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants its use.

j. Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.

k. 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 and a first-time complete denture including six months' postdelivery care. An immediate denture and a first-time complete denture are payable when the denture is provided to establish masticatory function. An immediate denture or a first-time complete denture is payable only once following the removal of teeth it replaces. A complete denture is payable only once in a five-year period except when the denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of complete dentures due to resorption in less than a five-year period is not payable.

b. A removable partial denture replacing anterior teeth, including six months' postdelivery care. A removable partial denture replacing anterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of a removable partial denture replacing anterior teeth due to resorption in less than a five-year period is not payable.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. A removable partial denture replacing posterior teeth shall be

approved when the member has fewer than eight posterior teeth in occlusion 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. A removable partial denture replacing posterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of a removable partial denture replacing posterior teeth due to resorption in less than a five-year period is not payable. (Cross-reference 78.28(2)*"c"*(1))

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth shall be approved for members whose medical condition precludes the use of a removable partial denture. High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing anterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.28(2)*"c"*(2))

e. A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth when prior approval has been received. A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth shall be approved for the member whose medical condition precludes the use of a removable partial denture and who has fewer than eight posterior teeth in occlusion or if 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 fixed partial denture brings eight posterior teeth in occlusion, no additional fixed partial denture will be approved. High noble or noble metals will be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing posterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.28(2)*"c"*(3))

f. Obturator for surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

g. Chairside relines are payable only once per prosthesis every 12 months.

h. Laboratory processed relines are payable only once per prosthesis every 12 months.

i. Tissue conditioning is a payable service twice per prosthesis in a 12-month period.

j. Two repairs per prosthesis in a 12-month period are payable.

k. 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.

l. 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.

78.4(8) *Orthodontic procedures.* Payment may be made for the following orthodontic procedures:

a. Orthodontic services to treat handicapping malocclusions are payable with prior approval. A score of 26 or above on the index from "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J. A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968, is required for approval.

(1) A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility to dental caries, and impaired speech due to malpositions of the teeth. Treatment of handicapping malocclusions will be approved only for the severe and the most handicapping. Assessment of the most handicapping malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, angle classification, overjet and overbite, openbite, and crossbite.

(2) A request to perform an orthodontic procedure must be accompanied by an interpreted cephalometric radiograph and study models trimmed so that the models simulate centric occlusion of

the patient. A written plan of treatment must accompany the diagnostic aids. Posttreatment records must be furnished upon request of the Iowa Medicaid enterprise.

(3) Approval may be made for eight units of a three-month active treatment period. Additional units may be approved by the Iowa Medicaid enterprise's orthodontic consultant if found to be medically necessary. (Cross-reference 78.28(2)"d")

b. Space management services shall be payable when there is too little dental ridge to accommodate either the number or the size of teeth and if not corrected significant dental disease will result.

c. Tooth guidance for a limited number of teeth or interceptive orthodontics is a payable service when extensive treatment is not required. Pretreatment records are not required.

78.4(9) *Treatment in a hospital.* Payment will be approved for dental treatment rendered a hospitalized patient only when the mental, physical, or emotional condition of the patient prevents the dentist from providing necessary care in the office.

78.4(10) *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.

78.4(11) *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 exams are not billed for that visit.

78.4(12) *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.

78.4(13) *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 writing prescriptions.

78.4(14) *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]

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 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.

d. Single vision and multifocal lens service, verification and subsequent service. When lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

(1) When 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 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) Protective lenses 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 six years of age.
3. When there is a prescribed 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.

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 once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Fitting of contact lenses when required following cataract surgery, documented keratoconus, aphakia, or for treatment of acute or chronic eye disease. Up to eight pairs of contact lenses are allowed for children up to one year of age with aphakia. Up to four pairs of contact lenses per year are allowed for children one to three years of age with aphakia.

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, manufactured by reputable American manufacturers.

b. Standard plastic, plastic and metal combination, or metal frames manufactured by reputable American manufacturers, if available.

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.

a. Materials payable by fee schedule are:

(1) 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) Protective lenses and safety frames.

(5) Subnormal visual aids.

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 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. (Cross-reference 78.28(3))

78.6(5) *Noncovered services.* Noncovered services include, but are not limited to, the following services:

a. Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.

b. Glasses for protective purposes including glasses for eye safety, sunglasses, or glasses with photogray lenses. An exception to this is in 78.6(3)*"b"*(4).

c. A second pair of glasses or spare glasses.

d. Cosmetic surgery and experimental medical and surgical procedures.

e. Contact lenses if vision is correctable with noncontact lenses except as found at paragraph 78.6(1)*"i."*

78.6(6) *Therapeutically certified optometrists.* Therapeutically certified optometrists may provide services and employ pharmaceutical agents in accordance with Iowa Code chapter 154 regulating the practice of optometry. A therapeutically certified optometrist is an optometrist who is licensed to practice optometry in this state and who is certified by the board of optometry to employ the agents and perform the procedures provided by the Iowa Code.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09]

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies shall be the same as described in rule 441—78.6(249A). (Cross-reference 78.28(3))

78.7(1) to **78.7(3)** Rescinded IAB 4/3/02, effective 6/1/02.

This rule is intended to implement Iowa Code section 249A.4.

441—78.8(249A) Chiropractors. Payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (Medicare).

78.8(1) *Covered services.* Chiropractic manipulative therapy (CMT) eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.

78.8(2) *Indications and limitations of coverage.*

a. The subluxation must have resulted in a neuromusculoskeletal condition set forth in the table below for which CMT is appropriate treatment. The symptoms must be directly related to the subluxation that has been diagnosed. The mere statement or diagnosis of "pain" is not sufficient to support the medical necessity of CMT. CMT must have a direct therapeutic relationship to the patient's condition. No other diagnostic or therapeutic service furnished by a chiropractor is covered under the Medicaid program.

ICD-9	CATEGORY I	ICD-9	CATEGORY II	ICD-9	CATEGORY III
307.81	Tension headache	353.0	Brachial plexus lesions	721.7	Traumatic spondylopathy
721.0	Cervical spondylosis without myelopathy	353.1	Lumbosacral plexus lesions	722.0	Displacement of cervical intervertebral disc without myelopathy
721.2	Thoracic spondylosis without myelopathy	353.2	Cervical root lesions, NEC	722.10	Displacement of lumbar intervertebral disc without myelopathy
721.3	Lumbosacral spondylosis without myelopathy	353.3	Thoracic root lesions, NEC	722.11	Displacement of thoracic intervertebral disc without myelopathy
723.1	Cervicalgia	353.4	Lumbosacral root lesions, NEC	722.4	Degeneration of cervical intervertebral disc
724.1	Pain in thoracic spine	353.8	Other nerve root and plexus disorders	722.51	Degeneration of thoracic or thoracolumbar intervertebral disc
724.2	Lumbago	719.48	Pain in joint (other specified sites, must specify site)	722.52	Degeneration of lumbar or lumbosacral intervertebral disc
724.5	Backache, unspecified	720.1	Spinal enthesopathy	722.81	Post laminectomy syndrome, cervical region
784.0	Headache	722.91	Calcification of intervertebral cartilage or disc, cervical region	722.82	Post laminectomy syndrome, thoracic region
		722.92	Calcification of intervertebral cartilage or disc, thoracic region	722.83	Post laminectomy syndrome, lumbar region
		722.93	Calcification of intervertebral cartilage or disc, lumbar region	724.3	Sciatica
		723.0	Spinal stenosis in cervical region		
		723.2	Cervicocranial syndrome		
		723.3	Cervicobrachial syndrome		
		723.4	Brachial neuritis or radiculitis, NOC		
		723.5	Torticollis, unspecified		
		724.01	Spinal stenosis, thoracic region		
		724.02	Spinal stenosis, lumbar region		
		724.4	Thoracic or lumbosacral neuritis or radiculitis		

ICD-9	CATEGORY I	ICD-9	CATEGORY II	ICD-9	CATEGORY III
		724.6	Disorders of sacrum, ankylosis		
		724.79	Disorders of coccyx, coccygodynia		
		724.8	Other symptoms referable to back, facet syndrome		
		729.1	Myalgia and myositis, unspecified		
		729.4	Fascitis, unspecified		
		738.40	Acquired spondylolisthesis		
		756.12	Spondylolisthesis		
		846.0	Sprains and strains of sacroiliac region, lumbosacral (joint; ligament)		
		846.1	Sprains and strains of sacroiliac region, sacroiliac ligament		
		846.2	Sprains and strains of sacroiliac region, sacrospinatus (ligament)		
		846.3	Sprains and strains of sacroiliac region, sacrotuberous (ligament)		
		846.8	Sprains and strains of sacroiliac region, other specified sites of sacroiliac region		
		847.0	Sprains and strains, neck		
		847.1	Sprains and strains, thoracic		
		847.2	Sprains and strains, lumbar		
		847.3	Sprains and strains, sacrum		
		847.4	Sprains and strains, coccyx		

b. The neuromusculoskeletal conditions listed in the table in paragraph *"a"* generally require short-, moderate-, or long-term CMT. A diagnosis or combination of diagnoses within Category I generally requires short-term CMT of 12 per 12-month period. A diagnosis or combination of diagnoses within Category II generally requires moderate-term CMT of 18 per 12-month period. A diagnosis or combination of diagnoses within Category III generally requires long-term CMT of 24 per 12-month period. For diagnostic combinations between categories, 28 CMTs are generally required per 12-month period. If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.

c. CMT is not a covered benefit when:

(1) The maximum therapeutic benefit has been achieved for a given condition.

(2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient's condition.

(3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

78.8(3) *Documenting X-ray.* An X-ray must document the primary regions of subluxation being treated by CMT.

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or

3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment shall be made for subsequent X-rays, absent a new condition, consistent with paragraph *"c"* of this subrule. No X-ray is required for pregnant women and for children aged 18 and under.

b. The X-ray films shall be labeled with the patient's name and date the X-rays were taken and shall be marked right or left. The X-ray shall be made available to the department or its duly authorized representative when requested. A written and dated X-ray report, including interpretation and diagnosis, shall be present in the patient's clinical record.

c. Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which major commercial payors reimburse chiropractors. The Iowa Medicaid enterprise shall publish in the Chiropractic Services Provider Manual the current list of payable X-ray CPT codes. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays shall be further limited to one per condition, consistent with the provisions of paragraph *"a"* of this subrule. A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph *"a"* of this subrule. A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor's office. Any X-rays so ordered shall be payable to the X-ray provider, consistent with the provisions in this paragraph.

This rule is intended to implement Iowa Code section 249A.4.

441—78.9(249A) Home health agencies. Payment shall be approved for medically necessary home health agency services prescribed by a physician in a plan of home health care provided by a Medicare-certified home health agency.

The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

The member need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency shall only be covered when provided in the member's residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at 78.9(10)*"a"* may be provided in settings other than the member's residence when medically necessary.

Medicaid members of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) to 78.9(10).

Payment shall be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed $15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the member's community.

Payment may be made for restorative and maintenance home health agency services.

Payment may be made for teaching, training, and counseling in the provision of health care services.

Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or

counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

Services shall be authorized by a physician, evidenced by the physician's signature and date on a plan of treatment.

78.9(1) *Treatment plan.* A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 62 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

a. Place of service.
b. Type of service to be rendered and the treatment modalities being used.
c. Frequency of the services.
d. Assistance devices to be used.
e. Date home health services were initiated.
f. Progress of member in response to treatment.
g. Medical supplies to be furnished.
h. Member's medical condition as reflected by the following information, if applicable:
(1) Dates of prior hospitalization.
(2) Dates of prior surgery.
(3) Date last seen by a physician.
(4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
(5) Prognosis.
(6) Functional limitations.
(7) Vital signs reading.
(8) Date of last episode of instability.
(9) Date of last episode of acute recurrence of illness or symptoms.
(10) Medications.
i. Discipline of the person providing the service.
j. Certification period (no more than 62 days).
k. Estimated date of discharge from the hospital or home health agency services, if applicable.
l. Physician's signature and date. The plan of care must be signed and dated by the physician before the claim for service is submitted for reimbursement.

78.9(2) *Supervisory visits.* Payment shall be made for supervisory visits two times a month when a registered nurse acting in a supervisory capacity provides supervisory visits of services provided by a home health aide under a home health agency plan of treatment or when services are provided by an in-home health care provider under the department's in-home health-related care program as set forth in 441—Chapter 177.

78.9(3) *Skilled nursing services.* Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services shall be defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end shall be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections shall be covered when ordered by a physician and included in the plan of

care. Other daily skilled nursing visits which are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and shall be denied.

Skilled nursing services shall be evaluated based on the complexity of the service and the condition of the patient.

Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

78.9(4) *Physical therapy services.* Payment shall be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"b."*

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(5) *Occupational therapy services.* Payment shall be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"c."*

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(6) *Speech therapy services.* Payment shall be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"d."*

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(7) *Home health aide services.* Payment shall be made for unskilled services provided by a home health aide if the following conditions are met:

a. The service as well as the frequency and duration are stated in a written plan of treatment established by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

b. The member requires personal care services as determined by a registered nurse or other appropriate therapist. The services shall be given under the supervision of a registered nurse, physical, speech, or occupational therapist and the registered nurse or therapist shall assign the aide who will provide the care.

c. Services shall be provided on an intermittent basis. "Intermittent basis" for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician and included in a plan of care shall be allowed as intermittent services. Increased services provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

Personal care services include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services

furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the member, e.g., lives alone or with family.

78.9(8) *Medical social services.*

a. Payment shall be made for medical social work services when all of the following conditions are met and the problems are not responding to medical treatment and there does not appear to be a medical reason for the lack of response. The services:

(1) Are reasonable and necessary to the treatment of a member's illness or injury.

(2) Contribute meaningfully to the treatment of the member's condition.

(3) Are under the direction of a physician.

(4) Are provided by or under the supervision of a qualified medical or psychiatric social worker.

(5) Address social problems that are impeding the member's recovery.

b. Medical social services directed toward minimizing the problems an illness may create for the member and family, e.g., encouraging them to air their concerns and providing them with reassurance, are not considered reasonable and necessary to the treatment of the patient's illness or injury.

78.9(9) *Home health agency care for maternity patients and children.* The intent of home health agency services for maternity patients and children shall be to provide services when the members are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician's office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

a. Treatment plans for maternity patients and children shall identify:

(1) The potential risk factors,

(2) The medical factor or symptom which verifies the child is at risk,

(3) The reason the member is unable to obtain care outside of the home,

(4) The medically related task of the home health agency,

(5) The member's diagnosis,

(6) Specific services and goals, and

(7) The medical necessity for the services to be rendered. A single high-risk factor does not provide sufficient documentation of the need for services.

b. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:

(1) Aged 16 or under.

(2) First pregnancy for a woman aged 35 or over.

(3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.

(4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.

(5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.

(6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.

(7) Second pregnancy in 12 months.

(8) Death of a close family member or significant other within the previous year.

c. The following list of potential high-risk factors may indicate a need for home health services to postpartum maternity patients:

(1) Aged 16 or under.

(2) First pregnancy for a woman aged 35 or over.

(3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.

(4) Preexisting mental or physical disabilities such as deaf, blind, hemaplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or mental retardation.

(5) Drug or alcohol abuse.

(6) Symptoms of postpartum psychosis.

(7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.

(8) Demonstrated disturbance in maternal and infant bonding.

(9) Discharge or release from hospital against medical advice before 36 hours postpartum.

(10) Insufficient antepartum care by history.

(11) Multiple births.

(12) Nonhospital delivery.

d. The following list of potential high-risk factors may indicate a need for home health services to infants:

(1) Birth weight of five pounds or under or over ten pounds.

(2) History of severe respiratory distress.

(3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.

(4) Disabling birth injuries.

(5) Extended hospitalization and separation from other family members.

(6) Genetic disorders, such as Down's syndrome, and phenylketonuria or other metabolic conditions that may lead to mental retardation.

(7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.

(8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.

(9) Discharge or release against medical advice before 36 hours of age.

(10) Nutrition or feeding problems.

e. The following list of potential high-risk factors may indicate a need for home health services to preschool or school-age children:

(1) Child or sibling victim of child abuse or neglect.

(2) Mental retardation or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.

(3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.

(4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.

(5) Malignancies such as leukemia or carcinoma.

(6) Severe injuries necessitating treatment or rehabilitation.

(7) Disruption in family or peer relationships.

(8) Suspected developmental delay.

(9) Nutritional deficiencies.

78.9(10) *Private duty nursing or personal care services for persons aged 20 and under.* Payment for private duty nursing or personal care services for persons aged 20 and under shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member. Enhanced payment under the interim fee schedule shall be made available for services to children who are technology dependent, i.e., ventilator dependent or whose medical condition is so unstable as to otherwise require intensive care in a hospital.

Private duty nursing or personal care services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.
5. Transportation services.
6. Homework assistance.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.28(9))

78.9(11) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, a home health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09; **ARC 9315B**, IAB 12/29/10, effective 2/2/11; **ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies.

78.10(1) *General payment requirements.* Payment will be made for items of DME, prosthetic devices and medical supplies, subject to the following general requirements and the requirements of subrule 78.10(2), 78.10(3), or 78.10(4), as applicable:

a. DME, prosthetic devices, and medical supplies must be required by the member because of the member's medical condition.

b. The item shall be necessary and reasonable either for the treatment of an illness or injury, or to improve the functioning of a malformed body part. Determination will be made by the Iowa Medicaid enterprise medical services unit.

(1) An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part.

(2) Although an item may be necessary, it must also be a reasonable expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness: Whether the expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item; whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and whether the item serves essentially the same purpose as an item already available to the beneficiary.

c. A physician's (doctor of medicine, osteopathy, or podiatry), physician assistant's, or advanced registered nurse practitioner's prescription is required to establish medical necessity. The prescription shall state the diagnosis, prognosis, and length of time the item is to be required.

For items requiring prior approval, 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 approval is made on Form 470-0829, Request for Prior Authorization. See rule 441—78.28(249A) for prior approval 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 patient, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item which meets the patient's medical needs. Payment will not be approved for duplicate items.

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 will be maintained on a rental basis for the duration of use.

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.

78.10(2) *Durable medical equipment.* DME is equipment which 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 will not be provided in a hospital, nursing facility, or intermediate care facility for persons with mental retardation. EXCEPTION: Medicaid will provide payment to medical equipment and supply dealers to provide oxygen services in a nursing facility or an intermediate care facility for persons with mental retardation when all of the following requirements and conditions have been met:

(1) A physician's, physician assistant's, or advanced registered nurse practitioner's prescription documents that the member has significant hypoxemia as defined by Medicare and evidenced by supporting medical documentation and the member requires oxygen for 12 hours or more per day for at least 30 days. Oxygen prescribed "PRN" or "as necessary" is not allowed. The documentation maintained in the provider record must contain the following:

1. The number of hours oxygen is required per day;
2. The diagnosis of the disease requiring continuous oxygen, prognosis, and length of time the oxygen will be needed;
3. The oxygen flow rate and concentration; the type of system ordered, i.e., cylinder gas, liquid gas, or concentrator;
4. A specific estimate of the frequency and duration of use; and
5. The initial reading on the time meter clock on each concentrator, where applicable.

(2) The maximum Medicaid payment shall be based on the least costly method of oxygen delivery.

(3) Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system, servicing and repairing of equipment are included in the Medicaid payment.

(4) Oxygen logs must be maintained by the provider. When random postpayment review of these logs indicates less than an average of 12 hours per day of oxygen was provided over a 30-day period, recoupment of the overpayment may occur.

(5) Payment will be made for only one mode of oxygen even if the physician's, physician assistant's, or advanced registered nurse practitioner's prescription allows for multiple modes of delivery.

(6) Payment will not be made for oxygen that is not documented according to department of inspections and appeals 481—subrule 58.21(8).

b. Only the following types of durable medical equipment can be covered through the Medicaid program:

Alternating pressure pump.

Automated medication dispenser. See 78.10(2)*"d"* for prior authorization requirements.

Bedpan.

Blood glucose monitors, subject to the limitation in 78.10(2)*"e."*

Blood pressure cuffs.

Cane.

Cardiorespiratory monitor (rental and supplies).
Commode.
Commode pail.
Crutches.
Decubitus equipment.
Dialysis equipment.
Diaphragm (contraceptive device).
Enclosed bed. See 78.10(2)*"d"* for prior authorization requirements.
Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.
Hospital bed.
Hospital bed accessories.
Inhalation equipment.
Insulin infusion pump. See 78.10(2)*"d"* for prior authorization requirements.
Lymphedema pump.
Neuromuscular stimulator.
Oximeter.
Oxygen, subject to the limitations in 78.10(2)*"a"* and 78.10(2)*"c."*
Patient lift (Hoyer).
Phototherapy bilirubin light.
Pressure unit.
Protective helmet.
Respirator.
Resuscitator bags and pressure gauge.
Seat lift chair.
Suction machine.
Traction equipment.
Urinal (portable).
Vaporizer.
Ventilator.
Vest airway clearance system. See 78.10(2)*"d"* for prior authorization requirements.
Walker.
Wheelchair—standard and adaptive.
Whirlpool bath.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary only for members with significant hypoxemia as defined by Medicare and shown by supporting medical documentation. The physician's, physician assistant's, or advanced registered nurse practitioner's prescription 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 at one year of age and at two years of age and documented in the provider record.

(1) To identify the medical necessity for oxygen therapy, the supplier and a physician, physician assistant, or advanced registered nurse practitioner shall jointly submit Medicare Form B-7401, Physician's Certification for Durable Medical Equipment, or a reasonable facsimile. The following information is required:

1. A diagnosis of the disease requiring home use of oxygen;
2. The oxygen flow rate and concentration;
3. The type of system ordered, i.e., cylinder gas, liquid gas, or concentrator;
4. A specific estimate of the frequency and duration of use; and
5. The initial reading on the time meter clock on each concentrator, where applicable.

Oxygen prescribed "PRN" or "as necessary" is not allowed.

(2) If the patient'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 (doctor of medicine or osteopathy), physician assistant, or advanced registered nurse practitioner of the medical necessity for portable oxygen for specific activities.

(4) Payment for concentrators shall be made only on a rental basis.

(5) All accessories, disposable supplies, servicing, and repairing of concentrators are included in the monthly Medicaid payment for concentrators.

d. Prior authorization is required for the following medical equipment and supplies (Cross-reference 78.28(1)):

(1) Enclosed beds. Payment for an enclosed bed will be approved when prescribed for a patient who meets all of the following conditions:

1. The patient has a diagnosis-related cognitive or communication impairment that results in risk to safety.
2. The patient's mobility puts the patient at risk for injury.
3. The patient has suffered injuries when getting out of bed.

(2) External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

(3) Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a patient 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 of lung function.
2. The patient 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.

(4) Automated medication dispenser. Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:

1. The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.
2. The member is on two or more medications prescribed to be administered more than one time a day.
3. The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.
4. Less costly alternatives, such as medisets or telephone reminders, have failed.

(5) Blood glucose monitors and diabetic test strips produced by a manufacturer that does not have a current agreement to provide a rebate to the department for monitors or test strips provided through the Medicaid program. Prior approval shall be granted when the member's medical condition necessitates use of a blood glucose monitor or diabetic test strips produced by a manufacturer that does not have a current rebate agreement with the department.

e. Blood glucose monitors are covered through the Medicaid program only if:

(1) The monitor is produced by a manufacturer that has a current agreement to provide a rebate to the department for monitors provided through the Medicaid program; or

(2) Prior authorization based on medical necessity is received pursuant to rule 441—79.8(249A) for a monitor produced by a manufacturer that does not have a current rebate agreement with the department.

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 patient's condition may improve sometime in the future.

a. Prosthetic devices are not covered when dispensed to a patient prior to the time the patient undergoes a procedure which will make necessary the use of the device.

b. Only the following types of prosthetic devices shall be covered through the Medicaid program:

(1) Artificial eyes.

(2) Artificial limbs.

(3) Augmentative communications systems provided for members unable to communicate their basic needs through oral speech or manual sign language. Payment will be made for the most cost-effective item that meets basic communication needs commensurate with the member's cognitive and language abilities. See 78.10(3)*"c"* for prior approval requirements.

(4) Enteral delivery supplies and products. See 78.10(3)*"c"* for prior approval requirements.

(5) Hearing aids. See rule 441—78.14(249A).

(6) Oral nutritional products. See 78.10(3)*"c"* for prior approval requirements. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for the mentally retarded.

(7) Orthotic devices. See 78.10(3)*"d"* for limitations on coverage of cranial orthotic devices.

(8) Ostomy appliances.

(9) 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.

(10) Prosthetic shoes. See rule 441—78.15(249A).

(11) Tracheotomy tubes.

(12) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross-reference 78.28(4))

c. Prior approval is required for the following prosthetic devices:

(1) Augmentative communication systems. Form 470-2145, Augmentative Communication System Selection, completed by a speech pathologist and a physician's, physician assistant's, or advanced registered nurse practitioner's prescription for a particular device shall be submitted to the Iowa Medicaid enterprise medical services unit to request prior approval. Information requested on the prior approval form includes a medical history, diagnosis, and prognosis completed by a physician, physician assistant, or advanced registered nurse practitioner. In addition, a speech or language pathologist needs to describe current functional abilities in the following areas: communication skills, motor status, sensory status, cognitive status, social and emotional status, and language status. Also needed from the speech or language pathologist is information on educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. The department's consultants with expertise in speech pathology will evaluate the prior approval requests and make recommendations to the department. (Cross-reference 78.28(1)*"c"*)

(2) Enteral products and enteral delivery pumps and supplies. Daily enteral nutrition therapy shall be approved as medically necessary only for a member who either has a metabolic or digestive disorder that prevents the member from obtaining the necessary nutritional value from usual foods in any form and cannot be managed by avoidance of certain food products or has a severe pathology of the body that does not allow ingestion or absorption of sufficient nutrients from regular food to maintain weight and strength commensurate with the member's general condition.

A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for enteral products and enteral delivery pumps and supplies pursuant to the above standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic or digestive disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation of the medical necessity for an enteral pump, if the request includes an enteral pump. The information submitted must identify the medical reasons for not using a gravity feeding set.

Examples of conditions that will not justify approval of enteral nutrition therapy are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under five years of age and coverage through the Women, Infant and Children's program is not available), and the use of enteral products for convenience reasons when regular food in pureed form would meet the medical need of the member.

Basis of payment for nutritional therapy supplies shall be the least expensive method of delivery that is reasonable and medically necessary based on the documentation submitted.

(3) Oral nutritional products. Payment for oral nutritional products shall be approved as medically necessary only 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 the mentally retarded. A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for oral supplementation pursuant to these standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic, digestive, or psychological disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation to support the fact that regular foods will not provide sufficient nutritional value to the member. Examples of conditions that will not justify approval of oral supplementation are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under five years of age and coverage through the Women, Infant and Children's program is not available), supplementation to boost calorie or protein intake by less than 51 percent of the daily intake, and the absence of severe pathology of the body or psychological pathology or disorder.

d. 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 photographic evidence supporting moderate to severe nonsynostotic positional plagiocephaly and either:

(1) The member is between 3 and 5 months of age and has failed to respond to a two-month trial of repositioning therapy; or

(2) The member is between 6 and 18 months 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. Only the following types of medical supplies and supplies necessary for the effective use of a payable item can be purchased through the medical assistance program:

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 blood glucose test strips, subject to the limitation in 78.10(4)*"c."*

Diabetic supplies, other than blood glucose test strips (needles, syringes, and diabetic urine test supplies).

Dialysis supplies.

Diapers (for members aged four and above).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Disposable underpads.

Dressings.

Elastic antiembolism support stocking.

Enema.

Hearing aid batteries.

Respirator supplies.

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 the mentally retarded when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.

Diabetic supplies (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).

c. Diabetic blood glucose test strips are covered through the Medicaid program only if:

(1) The strips are produced by a manufacturer that has a current agreement to provide a rebate to the department for test strips provided through the Medicaid program, or

(2) Prior authorization is received pursuant to rule 441—79.8(249A) for test strips produced by a manufacturer that does not have a current rebate agreement with the department, based on medical necessity.

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]

441—78.11(249A) Ambulance service. Payment will be approved for ambulance service if it is required by the recipient's condition and the recipient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home or to a nursing facility. Payment for ambulance service to the nearest hospital for outpatient service will be approved only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

78.11(2) The Iowa Medicaid enterprise medical services unit shall determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician's confirmation when:

a. The individual is admitted as a hospital inpatient or in an emergency situation.

b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

78.11(3) When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements shall not be applicable. Approval for transfer shall be made by the local office of the department of human services prior to the transfer. When such a transfer is made, the following rate schedule shall apply:

One patient - normal allowance

Two patients - 3/4 normal allowance per patient

Three patients - 2/3 normal allowance per patient

Four patients - 5/8 normal allowance per patient

78.11(4) Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 441—paragraph 79.1(5)*"j."*

78.11(5) In the event that more than one ambulance service is called to provide ground ambulance transport, payment shall be made only to one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

This rule is intended to implement Iowa Code section 249A.4.

441—78.12(249A) Behavioral health intervention. Payment will be made for behavioral health intervention services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of an Axis I psychological disorder, subject to the limitations in this rule.

78.12(1) *Definitions.*

"Axis I disorder" means a diagnosed mental disorder, except for personality disorders and mental retardation, as set forth in the "Diagnostic and Statistical Manual IV-TR," Fourth Edition.

"Behavioral health intervention" means skill-building services that focus on:

1. Addressing the mental and functional disabilities that negatively affect a member's integration and stability in the community and quality of life;

2. Improving a member's health and well-being related to the member's Axis I disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member's best possible functional level; and

3. Promoting a member's mental health recovery and resilience through increasing the member's ability to manage symptoms.

"Licensed practitioner of the healing arts" or *"LPHA,"* as used in this rule, means a practitioner such as a physician (M.D. or D.O.), an advanced registered nurse practitioner (ARNP), a psychologist, a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who:

1. Is licensed by the applicable state authority for that profession;

2. Is enrolled in the Iowa Plan for Behavioral Health (Iowa Plan) pursuant to 441—Chapter 88, Division IV; and

3. Is qualified to provide clinical assessment services (Current Procedural Terminology code 90801) under the Iowa Plan pursuant to 441—Chapter 88, Division IV.

78.12(2) *Covered services.*

a. Service setting.

(1) Community-based behavioral health intervention is available to a member living in a community-based environment. Services have a primary goal of assisting the member and the member's family to learn age-appropriate skills to manage behavior and regain or retain self-control. Depending on the member's age and diagnosis, specific services offered may include:

1. Behavior intervention,
2. Crisis intervention,
3. Skill training and development, and
4. Family training.

(2) Residential behavioral health intervention is available to members eligible for foster group care payment pursuant to 441—subrule 156.20(1). Services have the primary goal of assisting the member to prepare to transition to the community through learning age-appropriate skills to manage behavior and regain or retain self-control. Specific services offered include:

1. Behavior intervention,
2. Crisis intervention, and
3. Family training.

(3) Behavioral health intervention is not covered for members who are in an acute care or psychiatric hospital, a long-term care facility, or a psychiatric medical institution for children.

b. Crisis intervention. Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists.

(1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.

(3) Crisis intervention services do not include control room or other restraint activities.

c. Behavior intervention. Behavior intervention includes services designed to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.

(1) Interventions may address the following skills for effective functioning with family, peers, and community in an age-appropriate manner:

1. Cognitive flexibility skills,
2. Communication skills,
3. Conflict resolution skills,
4. Emotional regulation skills,
5. Executive skills,
6. Interpersonal relationship skills,
7. Problem-solving skills, and
8. Social skills.

(2) Behavior intervention shall be provided in a location appropriate for skill identification, teaching and development. Intervention may be provided in an individual, family, or group format as appropriate to meet the member's needs.

(3) Behavior intervention is covered only for Medicaid members aged 20 or under.

(4) Covered services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.

d. Family training. Family training is covered only for Medicaid members aged 20 or under.

(1) Family training services shall:

1. Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and

2. Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.

(2) Training provided must:

1. Be for the direct benefit of the member, and

2. Be based on a curriculum with a training manual.

e. Skill training and development. Skill training and development services are covered for Medicaid members aged 18 or over.

(1) Skill training and development shall consist of interventions to:

1. Enhance a member's independent living, social, and communication skills;

2. Minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and

3. Maximize a member's ability to live and participate in the community.

(2) Interventions may include training in the following skills for effective functioning with family, peers, and community:

1. Communication skills,

2. Conflict resolution skills,

3. Daily living skills,

4. Employment-related skills,

5. Interpersonal relationship skills,

6. Problem-solving skills, and

7. Social skills.

78.12(3) *Excluded services.*

a. Services that are habilitative in nature are not covered under behavioral health intervention. For purposes of this subrule, "habilitative services" means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

b. Respite, day care, education, and recreation services are not covered under behavioral health intervention.

78.12(4) *Coverage requirements.* Medicaid covers behavioral health intervention only when the following conditions are met:

a. A licensed practitioner of the healing arts acting within the practitioner's scope of practice under state law has diagnosed the member with a psychological disorder.

b. The licensed practitioner of the healing arts has recommended the behavioral health intervention as part of a plan of treatment designed to treat the member's psychological disorder. The plan of treatment shall be comprehensive in nature and shall detail all behavioral health services that the member may require, not only services included under behavioral health intervention.

(1) The member's need for services must meet specific individual goals that are focused to address:

1. Risk of harm to self or others,

2. Behavioral support in the community,

3. Specific skills impaired due to the member's mental illness, and

4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.

(2) Diagnosis and treatment plan development provided in connection with this rule for members enrolled in the Iowa Plan are covered services under the Iowa Plan pursuant to 441—Chapter 88, Division IV.

c. For a member under the age of 21, the licensed practitioner of the healing arts:

(1) Has, in cooperation with the managed care contractor, selected a standardized assessment instrument appropriate for baseline measurement of the member's current skill level in managing mental health needs;

(2) Has completed an initial formal assessment of the member using the instrument selected; and

(3) Completes a formal assessment every six months thereafter if continued services are ordered.

d. The behavioral health intervention provider has prepared a written services implementation plan that meets the requirements of subrule 78.12(5).

78.12(5) *Approval of plan.* The behavioral health intervention provider shall contact the Iowa Plan provider for authorization of the services.

a. Initial plan. The initial services implementation plan must meet all of the following criteria:

(1) The plan conforms to the medical necessity requirements in subrule 78.12(6);

(2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;

(3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

(4) The provider meets the requirements of rule 441—77.12(249A); and

(5) The plan does not exceed six months' duration.

b. Subsequent plans. The Iowa Plan contractor may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)*"a"* if the services are recommended by a licensed practitioner of the healing arts who has:

(1) Reexamined the member;

(2) Reviewed the original diagnosis and treatment plan; and

(3) Evaluated the member's progress, including a formal assessment as required by 78.12(4)*"c"*(3).

78.12(6) *Medical necessity.* Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, "medically necessary" means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by an Axis I disorder;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:

(1) Knowledgeable Iowa clinicians practicing or teaching in the field; and

(2) The professional literature regarding evidence-based practices in the field.

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[**ARC 8504B**, IAB 2/10/10, effective 3/22/10; **ARC 9487B**, IAB 5/4/11, effective 7/1/11]

441—78.13(249A) Nonemergency medical transportation. Nonemergency transportation to receive medical care, including any reimbursement of transportation expenses incurred by a Medicaid member, shall be provided through the broker designated by the department pursuant to a contract between the department and the broker, as specified in this rule.

78.13(1) *Member request.* When a member needs nonemergency transportation, one way or round trip, to receive medical care provided by the Medicaid program, including any reimbursement of transportation expenses incurred by the member, the member must contact the broker in advance. The broker shall establish and publicize the procedures for members to request transportation services. The broker is required to provide transportation within 72 hours of a request only if receipt of medical care within 72 hours is medically necessary.

78.13(2) *Necessary services.* Transportation shall be provided only when the member needs transportation to receive necessary services covered by the Iowa Medicaid program from an enrolled provider, including transportation needed to obtain prescribed drugs.

78.13(3) *Access to free transportation.* Transportation shall be provided only if the member does not have access to transportation that is available at no cost to the member, such as transportation provided by volunteers, relatives, friends, social service agencies, nursing facilities, residential care centers, or any

other source. EXCEPTION: If a prescribed drug is needed immediately, transportation will be provided to obtain the drug even if free delivery is available.

78.13(4) *Closest medical provider.* Transportation beyond 20 miles (one way) shall be provided only to the closest qualified provider unless:

a. The difference between the closest qualified provider and the provider requested by the member is less than 10 miles (one way); or

b. The additional cost of transportation to the provider requested by the member is medically justified based on:

(1) A previous relationship between the member and the requested provider,

(2) Prior experience of the member with closer providers, or

(3) Special expertise or experience of the requested provider.

78.13(5) *Coverage.* Based on the information provided by the member and the provisions of this rule, the broker shall arrange and reimburse for the most economical form of transportation appropriate to the needs of the member.

a. The broker may require that public transportation be used when reasonably available and the member's condition does not preclude its use.

b. The broker may arrange and reimburse for transportation by arranging to reimburse the member for transportation expenses. In that case, the member shall submit transportation expenses to the broker on Form 470-0386, Medical Transportation Claim, or an equivalent electronic form.

c. When a member is unable to travel alone due to age or due to physical or mental incapacity, the broker shall provide for the expenses of an attendant.

d. The broker shall provide for meals, lodging, and other incidental transportation expenses required for the member and for any attendant required due to the age or incapacity of the member in connection with transportation provided under this rule.

78.13(6) *Exceptions for nursing facility residents.*

a. Nonemergency medical transportation for residents of nursing facilities within 30 miles of the nursing facility (one way) shall not be provided through the broker but shall be the responsibility of the nursing facility.

b. Nonemergency medical transportation for residents of nursing facilities beyond 30 miles from the nursing facility (one way) shall be provided through the broker, but the nursing facility shall contact the broker on behalf of the resident.

78.13(7) *Grievances.* Pursuant to its contract with the department, the broker shall establish an internal grievance procedure for members and transportation providers. Members who have exhausted the grievance process may appeal to the department pursuant to 441—Chapter 7 as an "aggrieved person." For transportation providers, the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8994B**, IAB 8/11/10, effective 10/1/10]

441—78.14(249A) Hearing aids. Payment shall be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) *Physician examination.* The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

a. Has been advised that it may be in the member's best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.

b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) *Audiological testings.* A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) *Hearing aid evaluation.* A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) *Hearing aid selection.* A physician or audiologist may recommend a specific brand or model appropriate to the member's condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member's condition.

78.14(5) *Travel.* When a member is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the member's place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) *Purchase of hearing aid.* The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:

a. A child needs the aid for speech development,

b. The aid is needed for educational or vocational purposes,

c. The aid is for a blind member,

d. The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or

e. Lack of binaural amplification poses a hazard to a member's safety.

78.14(7) *Payment for hearing aids.*

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist's fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer's invoice. Payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1)*"a."*

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid. (Cross-reference 78.28(4)*"a"*)

(2) Payment for a hearing aid costing more than $650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross-reference 78.28(4)*"b"*):

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise

or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 8008B**, IAB 7/29/09, effective 8/1/09]

441—78.15(249A) Orthopedic shoes. Payment shall be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) *Definitions.*

"Custom-molded shoe" means a shoe that:

1. Has been constructed over a cast or model of the recipient's foot;
2. Is made of leather or another suitable material of equal quality;
3. Has inserts that can be removed, altered, or replaced according to the recipient's conditions and needs; and
4. Has some form of closure.

"Depth shoe" means a shoe that:

1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
2. Is made from leather or another suitable material of equal quality;
3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

"Insert" means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient's foot or is made over a model of the foot.

78.15(2) *Prescription.* The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:

1. The date.
2. The patient's diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

78.15(3) *Diagnosis.* The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the current version of the International Classification of Diseases (ICD). A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

(1) The reasons the recipient cannot be fitted with a depth shoe.
(2) Pain.
(3) Tissue breakdown or a high probability of tissue breakdown.
(4) Any limitation on walking.

78.15(4) *Frequency.* Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

This rule is intended to implement Iowa Code section 249A.4.

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center.

Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1)*"b"* with the following exceptions:

(1) Services by staff psychiatrists, or

(2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or

(3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients' treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

(3) and (4) Rescinded IAB 2/5/03, effective 2/1/03.

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1)*"b"*(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1)*"b"*(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department of human services or department designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6)*"b."*

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

c. Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor's degree in a human services related field from an accredited college or university; or

(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

d. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(7).

78.16(7) Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

a. Program documentation. Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative which provides the following day treatment program information:

(1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs *"c"* to *"h"* below.

(3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Program standards. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall:

1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—33.1(225C,230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support,

nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.

2. Reflect how program continuity will be provided.

3. Reflect an interdisciplinary team of professionals and paraprofessionals.

4. Include a designated director who is a mental health professional as defined in rule 441—33.1(225C,230A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

5. Be provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor's degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

c. Program services. Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve

the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient's condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services (examples would include individual, group, and family therapy).

(2) Psychosocial rehabilitation services. Active treatment examples include, but are not limited to, individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment which reflect current functioning may be used as an update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program. Hours in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

d. Admission criteria. Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

(1) The patient is at risk for exclusion from normative community activities or residence.

(2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.

(3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.

(4) The patient's principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient's behavior, and must be involved in the patient's treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(5) The patient has the capacity to benefit from the interventions provided.

e. Individual treatment plan. Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient's strengths and weaknesses and identify areas of therapeutic focus. The treatment goals which are general statements of consumer outcomes shall be related to identified strengths, weaknesses, and clinical needs with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered either on the "National Register of Health Service Providers in Psychology" or the "Iowa Register of Health Service Providers for Psychology." Approval will be evidenced by a signature of the physician or health service provider.

f. Discharge criteria. Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

(1) In the case of patient improvement:

1. The patient's clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient's developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.

2. Treatment goals in the individualized treatment plan have been achieved.

3. An aftercare plan has been developed that is appropriate to the patient's needs and agreed to by the patient and family, custodian, or guardian.

(2) If the patient does not improve:

1. The patient's clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.

2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

g. Coordination of services. Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active

role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

h. Stable milieu. The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient's social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

i. Chronic mental illness. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(6).

This rule is intended to implement Iowa Code section 249A.4.

441—78.17(249A) Physical therapists. Payment will be approved for the same services payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4.

441—78.18(249A) Screening centers. Payment will be approved for health screening as defined in 441—subrule 84.1(1) for Medicaid members under 21 years of age.

78.18(1) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, a screening center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:

(1) Six screenings in the first year of life.

(2) Four screenings between the ages of 1 and 2.

(3) One screening a year at ages 3, 4, 5, and 6.

(4) One screening a year at ages 8, 10, 12, 14, 16, 18, and 20.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

78.18(6) Rescinded IAB 12/3/08, effective 2/1/09.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment shall be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.19(249A) Rehabilitation agencies.

78.19(1) *Coverage of services.*

a. General provisions regarding coverage of services.

(1) Services are provided in the recipient's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. Services provided a recipient residing in a nursing facility or residential care facility are payable when a statement is submitted signed by the facility that the facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes. Payment will not be made to a rehabilitation agency for therapy provided to a recipient residing in an intermediate care facility for the mentally retarded since these facilities are responsible for providing or paying for services required by recipients.

(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.

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4.

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program (Title XVIII of the Social Security Act). Payment will be made for sterilization in accordance with 78.1(16).

78.21(1) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.21(2) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.21(3) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, a rural health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with 78.1(16).

78.22(2) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, a family planning clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, which provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) *Sterilization.* Payment will be made for sterilization in accordance with 78.1(16).

78.23(2) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.23(3) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.23(4) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, a clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist shall be made on a fee for service basis.

a. Payment shall be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

e. Mileage at the same rate as in 78.1(8) when the following conditions are met:

(1) It is necessary for the psychologist to travel outside of the home community, and

(2) There is no qualified mental health professional more immediately available in the community, and

(3) The member has a medical condition which prohibits travel.

f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

c. Psychological examinations employing unusual or experimental instrumentation.

d. Individual and group psychotherapy without specification of condition, symptom, or complaint.

e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Rescinded IAB 10/12/94, effective 12/1/94.

78.24(5) The following services shall require review by a consultant to the department.

a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.

b. Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.25(1) *Provider qualifications.*

a. Prenatal and postpartum medical services shall be provided by a physician, a physician assistant, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.

b. Rescinded IAB 12/3/08, effective 2/1/09.

c. Education services and postpartum home visits shall be provided by a registered nurse.

d. Nutrition services shall be provided by a licensed dietitian.

e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) *Services covered for all pregnant women.* Services provided may include:

a. Prenatal and postpartum medical care.

b. Health education, which shall include:

(1) Importance of continued prenatal care.

(2) Normal changes of pregnancy including both maternal changes and fetal changes.

(3) Self-care during pregnancy.

(4) Comfort measures during pregnancy.

(5) Danger signs during pregnancy.

(6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.

(7) Preparation for baby including feeding, equipment, and clothing.

(8) Education on the use of over-the-counter drugs.

(9) Education about HIV protection.

c. Home visit.

d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).

e. Dental hygiene services within the scope of practice as defined by the dental board at 650—paragraph 10.5(3)*"b."*

78.25(3) *Enhanced services covered for women with high-risk pregnancies.* Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented by Form 470-2942, Medicaid Prenatal Risk Assessment. An appropriately trained physician or advanced registered nurse practitioner must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

a. Rescinded IAB 12/3/08, effective 2/1/09.

b. Education, which shall include as appropriate education about the following:

(1) High-risk medical conditions.

(2) High-risk sexual behavior.

(3) Smoking cessation.

(4) Alcohol usage education.

(5) Drug usage education.

(6) Environmental and occupational hazards.

c. Nutrition assessment and counseling, which shall include:

(1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.

(2) Ongoing nutritional assessment.

(3) Development of an individualized nutritional care plan.

(4) Referral to food assistance programs if indicated.

(5) Nutritional intervention.

d. Psychosocial assessment and counseling, which shall include:

(1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.

(2) A profile of the client's family composition, patterns of functioning and support systems.

(3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.

e. A postpartum home visit within two weeks of the child's discharge from the hospital, which shall include:

(1) Assessment of mother's health status.

(2) Physical and emotional changes postpartum.

(3) Family planning.

(4) Parenting skills.

(5) Assessment of infant health.

(6) Infant care.

(7) Grief support for unhealthy outcome.

(8) Parenting of a preterm infant.

(9) Identification of and referral to community resources as needed.

78.25(4) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, a maternal health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical

procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's Web site.

78.26(1) Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:

a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;

b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and

c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(4) Limits on covered services.

a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.

b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.

c. Preprocedure review by the Iowa Foundation for Medical Care (IFMC) is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 1776 West Lakes Parkway, West Des Moines, Iowa 50266-8239, or in local hospital utilization review offices. (Cross-reference 78.28(6))

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 8205B**, IAB 10/7/09, effective 11/11/09]

441—78.27(249A) Home- and community-based habilitation services.

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.

"Case management" means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

"Comprehensive service plan" means an individualized, goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

"Department" means the Iowa department of human services.

"Emergency" means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

"HCBS" means home- and community-based services.

"Interdisciplinary team" means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member's need for services.

"ISIS" means the department's individualized services information system.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

78.27(2) *Member eligibility.* To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

a. Risk factors. The member has at least one of the following risk factors:

(1) The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization) more than once in the member's life; or

(2) The member has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

b. Need for assistance. The member has a need for assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

(1) The member is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history.

(2) The member requires financial assistance for out-of-hospital maintenance and is unable to procure this assistance without help.

(3) The member shows severe inability to establish or maintain a personal social support system.

(4) The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, and medication management.

(5) The member exhibits inappropriate social behavior that results in a demand for intervention.

c. Income. The countable income used in determining the member's Medicaid eligibility does not exceed 150 percent of the federal poverty level.

d. Needs assessment. The member's case manager has completed an assessment of the member's need for service, and, based on that assessment, the Iowa Medicaid enterprise medical services unit has determined that the member is in need of home- and community-based habilitation services. A member who is not eligible for Medicaid case management services under 441—Chapter 90 shall receive case management as a home- and community-based habilitation service. The designated case manager shall:

(1) Complete a needs-based evaluation that meets the standards for assessment established in 441—subrule 90.5(1) before services begin and annually thereafter.

(2) Use the evaluation results to develop a comprehensive service plan as specified in subrule 78.27(4).

e. Plan for service. The department has approved the member's plan for home- and community-based habilitation services. A service plan that has been validated through ISIS shall be considered approved by the department. Home- and community-based habilitation services provided before department 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 case manager shall apply for services on behalf of a member by entering a program request for habilitation services in ISIS. The department shall issue a notice of decision to the applicant when financial eligibility, determination of needs-based eligibility, and approval of the service plan have been completed.

78.27(4) *Comprehensive service plan.* Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan 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 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 shall establish an interdisciplinary team for the member. The team shall include the case manager and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved.

(2) With the interdisciplinary team, the case manager 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 service plan and annual updates to the service plan must be approved by the Iowa Medicaid enterprise in the individualized services information system before services are implemented. Services provided before the approval date are not payable. The written case plan must be completed, signed and dated by the case manager or service worker within 30 calendar days after plan approval.

(10) Any changes to the service plan must be approved by the Iowa Medicaid enterprise in the individualized services information system before the implementation of services. Services provided before the approval date are not payable.

b. Service goals and activities. The comprehensive service plan shall:

(1) Identify observable or measurable individual goals.

(2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.

(4) List all Medicaid and non-Medicaid services received by the member and identify:

1. The name of the provider responsible for delivering the service;
2. The funding source for the service; and
3. The number of units of service to be received by the member.

(5) Identify for a member receiving home-based habilitation:

1. The member's living environment at the time of enrollment;
2. The number of hours per day of on-site staff supervision needed by the member; and
3. The number of other members who will live with the member in the living unit.

(6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

c. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan 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 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 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 service plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2)*"e."*

78.27(5) *Requirements for services.* Home- and community-based habilitation services shall be provided in accordance with the following requirements:

a. The services shall be based on the member's needs as identified in the member's comprehensive service plan.

b. The services shall be delivered in the least restrictive environment appropriate to the needs of the member.

c. The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.

d. Service components that are the same or similar shall not be provided simultaneously.

e. Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.

f. Reimbursement is not available for room and board.

g. Services shall be billed in whole units.

h. Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) *Case management.* Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Scope. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Exclusion. Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

78.27(7) *Home-based habilitation.* "Home-based habilitation" means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living in the community.

a. Scope. Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan. Covered supports include:

(1) Adaptive skill development;

(2) Assistance with activities of daily living;

(3) Community inclusion;

(4) Transportation;

(5) Adult educational supports;

(6) Social and leisure skill development;

(7) Personal care; and

(8) Protective oversight and supervision.

b. Exclusions. Home-based habilitation payment shall not be made for the following:

(1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.

(2) Service activities associated with vocational services, day care, medical services, or case management.

(3) Transportation to and from a day program.

(4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or "bundled" service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) *Day habilitation.* "Day habilitation" means assistance with acquisition, retention, or improvement of self-help, socialization, and adaptive skills.

a. Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services focus on enabling the member to attain or maintain the member's maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the comprehensive service plan. Services may serve to reinforce skills or lessons taught in other settings. Services must enhance or support the member's:

(1) Intellectual functioning;

(2) Physical and emotional health and development;

(3) Language and communication development;

(4) Cognitive functioning;

(5) Socialization and community integration;

(6) Functional skill development;

(7) Behavior management;

(8) Responsibility and self-direction;

(9) Daily living activities;

(10) Self-advocacy skills; or

(11) Mobility.

b. Setting. Day habilitation shall take place in a nonresidential setting separate from the member's residence. Services shall not be provided in the member's home. When the member lives in a residential care facility of more than 16 beds, day habilitation services provided in the facility are not considered to be provided in the member's home if the services are provided in an area apart from the member's sleeping accommodations.

c. Duration. Day habilitation services shall be furnished for four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

d. Exclusions. Day habilitation payment shall not be made for the following:

(1) Vocational or prevocational services.

(2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(3) Compensation to members for participating in day habilitation services.

78.27(9) *Prevocational habilitation.* "Prevocational habilitation" means services that prepare a member for paid or unpaid employment.

a. Scope. Prevocational habilitation services include teaching concepts such as compliance, attendance, task completion, problem solving, and safety. Services are not oriented to a specific job task, but instead are aimed at a generalized result. Services shall be reflected in the member's comprehensive service plan and shall be directed to habilitative objectives rather than to explicit employment objectives.

b. Setting. Prevocational habilitation services may be provided in a variety of community-based settings based on the individual need of the member. Meals provided as part of these services shall not constitute a full nutritional regimen (three meals per day).

c. Exclusions. Prevocational habilitation payment shall not be made for the following:

(1) Services that are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation

that funding is not available for the service under these programs shall be maintained in the file of each member receiving prevocational habilitation services.

(2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(3) Compensation to members for participating in prevocational services.

78.27(10) *Supported employment habilitation.* "Supported employment habilitation" means services associated with maintaining competitive paid employment.

a. Scope. Supported employment habilitation services are intensive, ongoing supports that enable members to perform in a regular work setting. Services are provided to members who need support because of their disabilities and who are unlikely to obtain competitive employment at or above the minimum wage absent the provision of supports. Covered services include:

(1) Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the member and the interdisciplinary team described in subrule 78.27(4) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the member's interdisciplinary team must determine that the identified services are necessary. Third, the Iowa Medicaid enterprise medical services unit must approve the services. Available components of activities to obtain a job are as follows:

1. Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A member may receive two units of job development services during a 12-month period. The activities provided to the member may include job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities; job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy; and customized job development services specific to the member.

2. Employer development services. The focus of employer development services is to support employers in hiring and retaining members in their workforce and to communicate expectations of the employers to the interdisciplinary team described in subrule 78.27(4). Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development services during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include: developing relationships with employers and providing leads for individual members when appropriate; job analysis for a specific job; development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities; identifying and arranging reasonable accommodations with the employer; providing disability awareness and training to the employer when it is deemed necessary; and providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.

3. Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the member for a minimum of 30 days or with assisting the member in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the member's employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include: job opening identification with the member; assistance with

applying for a job, including completion of applications or interviews; and work site assessment and job accommodation evaluation.

(2) Supports to maintain employment, including the following services provided to or on behalf of the member:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assistance in the use of skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Assistance with time management.
6. Assistance with appropriate grooming.
7. Employment-related supportive contacts.
8. On-site vocational assessment after employment.
9. Employer consultation.

b. Setting. Supported employment may be conducted in a variety of settings, particularly work sites where persons without disabilities are employed.

(1) The majority of coworkers at any employment site with more than two employees where members seek, obtain, or maintain employment must be persons without disabilities.

(2) In the performance of job duties at any site where members seek, obtain, or maintain employment, the member must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(3) When services for maintaining employment are provided to members in a teamwork or "enclave" setting, the team shall include no more than eight people with disabilities.

c. Service requirements. The following requirements shall apply to all supported employment services:

(1) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention.

(2) The provider shall provide employment-related adaptations required to assist the member in the performance of the member's job functions as part of the service.

(3) Community transportation options (such as carpools, coworkers, self or public transportation, families, volunteers) shall be attempted before the service provider provides transportation. When no other resources are available, employment-related transportation between work and home and to or from activities related to employment may be provided as part of the service.

(4) Members may access both services to maintain employment and services to obtain a job for the purpose of job advancement or job change. A member may receive a maximum of three job placements in a 12-month period and a maximum of 40 units per week of services to maintain employment.

d. Exclusions. Supported employment habilitation payment shall not be made for the following:

(1) Services that are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available under these programs shall be maintained in the file of each member receiving supported employment services.

(2) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing or maintaining members in day activity programs, work activity programs, or sheltered workshop programs.

(6) Supports for volunteer work or unpaid internships.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not member-specific.

78.27(11) *Adverse service actions.*

a. Denial. Services shall be denied when the department determines that:

(1) Rescinded IAB 12/29/10, effective 1/1/11.

(2) The member is not eligible for or in need of home- and community-based habilitation services.

(3) The service is not identified in the member's comprehensive service plan.

(4) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(5) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(6) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 30 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 30 consecutive days, the department will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. Appeal rights. The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

78.27(12) *County reimbursement.* The county board of supervisors of the member's county of legal settlement shall reimburse the department for all of the nonfederal share of the cost of home- and community-based habilitation services provided to an adult member with a chronic mental illness as defined in 441—Chapter 90. The department shall notify the county's central point of coordination administrator through ISIS of the approval of the member's service plan.

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]

441—78.28(249A) List of medical services and equipment requiring prior approval, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician (M.D. or D.O.) which are subject to prior approval or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code Supplement section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Automated medication dispenser. (Cross-reference 78.10(2)*"b"*) Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.

(2) The member is on two or more medications prescribed to be administered more than one time a day.

(3) The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.

(4) Less costly alternatives, such as medisets or telephone reminders, have failed.

c. Enteral products and enteral delivery pumps and supplies require prior approval. Daily enteral nutrition therapy shall be approved as medically necessary only for a member who either has a metabolic or digestive disorder that prevents the member from obtaining the necessary nutritional value from usual foods in any form and cannot be managed by avoidance of certain food products or has a severe pathology of the body that does not allow ingestion or absorption of sufficient nutrients from regular food to maintain weight and strength commensurate with the member's general condition. (Cross-reference 78.10(3)*"c"*(2))

(1) A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for enteral products and enteral delivery pumps and supplies pursuant to the above standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic or digestive disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation of the medical necessity for an enteral pump, if the request includes an enteral pump. The information submitted must identify the medical reasons for not using a gravity feeding set.

(2) Examples of conditions that will not justify approval of enteral nutrition therapy are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under five years of age and coverage through the Women, Infant and Children's program is not available), and the use of enteral products for convenience reasons when regular food in pureed form would meet the medical need of the member.

(3) Basis of payment for nutritional therapy supplies shall be the least expensive method of delivery that is reasonable and medically necessary based on the documentation submitted.

d. Rescinded IAB 5/11/05, effective 5/1/05.

e. Augmentative communication systems, which are provided to persons unable to communicate their basic needs through oral speech or manual sign language, require prior approval. Form 470-2145, Augmentative Communication System Selection, completed by a speech pathologist and a physician's prescription for a particular device shall be submitted to request prior approval. (Cross-reference 78.10(3)*"c"*(1))

(1) Information requested on the prior authorization form includes a medical history, diagnosis, and prognosis completed by a physician. In addition, a speech or language pathologist needs to describe current functional abilities in the following areas: communication skills, motor status, sensory status, cognitive status, social and emotional status, and language status.

(2) Also needed from the speech or language pathologist is information on educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations.

(3) The department's consultants with an expertise in speech pathology will evaluate the prior approval requests and make recommendations to the department.

f. Preprocedure review by the Iowa Foundation for Medical Care (IFMC) will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and on the published criteria established by the department and the IFMC. If not so approved by the IFMC, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from IFMC, 3737 Woodland Avenue, Suite 500, West Des Moines, Iowa 50265, or in local hospital utilization review offices.

The "Preprocedure Surgical Review List" shall be published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. (Cross-reference 78.1(19))

g. Prior authorization is required for enclosed beds. (Cross-reference 78.10(2)*"c"*) The department shall approve payment for an enclosed bed when prescribed for a patient who meets all of the following conditions:

(1) The patient has a diagnosis-related cognitive or communication impairment that results in risk to safety.

(2) The patient's mobility puts the patient at risk for injury.

(3) The patient has suffered injuries when getting out of bed.

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. Prior authorization is required for oral nutritional products. (Cross-reference 78.10(2)*"c"*) The department shall approve payment for oral nutritional products 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.

(1) A request for prior approval shall include a written order or prescription from a physician, physician assistant, or advanced registered nurse practitioner and documentation to establish the medical necessity for oral nutritional products pursuant to these standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic, digestive, or psychological disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation to support the fact that regular foods will not provide sufficient nutritional value to the member, if the request includes oral supplementation of a regular diet.

(2) Examples of conditions that will not justify approval of oral nutritional products are: weight-loss diets, wired-shut jaws, diabetic diets, and milk or food allergies (unless the member is under five years of age and coverage through the Special Supplemental Nutrition Program for Women, Infants, and Children is not available).

j. Prior authorization is required for vest airway clearance systems. (Cross-reference 78.10(2)*"c"*) The department shall approve payment for a vest airway clearance system when prescribed by a pulmonologist for a patient with a medical diagnosis related to a lung disorder if all of the following conditions are met:

(1) Pulmonary function tests for the 12 months before initiation of the vest demonstrate an overall significant decrease of lung function.

(2) The patient 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.

k. Prior authorization is required for blood glucose monitors and diabetic test strips produced by a manufacturer that does not have a current agreement to provide a rebate to the department for monitors or test strips provided through the Medicaid program. The department shall approve payment when a blood glucose monitor or diabetic test strips produced by a manufacturer that does not have a current rebate agreement with the department are medically necessary.

78.28(2) Dental services. Dental services which require prior approval are as follows:

a. The following periodontal services:

(1) Payment for periodontal scaling and root planing will be approved when interproximal and subgingival calculus is evident in X-rays or when justified and documented that curettage, scaling or root planing is required in addition to routine prophylaxis. (Cross-reference 78.4(4)*"b"*)

(2) Payment for pedicle soft tissue graft and free soft tissue graft will be approved when the written narrative describes medical necessity. Payment for other periodontal surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the patient has demonstrated reasonable oral hygiene, unless the patient is unable to demonstrate reasonable oral hygiene because of physical or mental disability or in cases which demonstrate gingival hyperplasia resulting from drug therapy. (Cross-reference 78.4(4)*"c"*)

(3) Payment for pedicle soft tissue graft and free soft tissue graft will be approved when the written narrative describes medical necessity. (Cross-reference 78.4(4)*"d"*)

(4) Payment for periodontal maintenance therapy may be approved after periodontal scaling and root planing or periodontal surgical procedures have been provided. Periodontal maintenance therapy may be approved once per three-month interval for moderate to advanced cases if the condition would deteriorate without treatment. (Cross-reference 78.4(4)*"e"*)

b. Surgical endodontic treatment which includes 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 will be approved when nonsurgical treatment has been attempted and a reasonable time 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 78.4(5)*"c"*)

c. The following prosthetic services:

(1) A removable partial denture replacing posterior teeth will be approved when the member has fewer than eight posterior teeth in occlusion 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. A removable partial denture replacing posterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure, and is required to prevent significant dental problems. Replacement of a removable partial denture replacing posterior teeth due to resorption in less than a five-year period is not payable. (Cross-reference 78.4(7)*"c"*)

(2) A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth will be approved for members whose medical condition precludes the use of a removable partial denture. High noble or noble metals will be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing anterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.4(7)*"d"*)

(3) A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth will be approved for members whose medical condition precludes the use of a removable partial denture and who have fewer than eight posterior teeth in occlusion or if 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 fixed partial denture brings eight posterior teeth in occlusion, no additional fixed partial denture will be approved. High noble or noble metals will be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing posterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.4(7)*"e"*)

(4) Dental implants and related services will be authorized 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.

d. Orthodontic services to treat a handicapping malocclusion are payable with prior approval. A score of 26 or above on the index from "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J. A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968, is required for approval.

(1) A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility to dental caries, and impaired speech due to malpositions of the teeth. Treatment of handicapping malocclusions will be approved only for the severe and the most handicapping. Assessment of the most handicapping malocclusion is determined by the magnitude of the following variables:

1. Degree of malalignment;
2. Missing teeth;
3. Angle classification;
4. Overjet and overbite;
5. Openbite; and
6. Crossbite.

(2) A request to perform an orthodontic procedure must be accompanied by an interpreted cephalometric radiograph and study models trimmed so that the models simulate centric occlusion of the patient. A written plan of treatment must accompany the diagnostic aids. Posttreatment records must be furnished upon request of the Iowa Medicaid enterprise medical services unit.

(3) Approval may be made for eight units of a three-month active treatment period. Additional units may be approved by the department's orthodontic consultant if the additional units are found to be medically necessary. (Cross-reference 78.4(8)*"a"*)

e. More than two laboratory-fabricated crowns will be approved in a 12-month period for anterior teeth that cannot be restored with a composite or amalgam restoration and for posterior teeth that cannot be restored with a composite or amalgam restoration or stainless steel crown. (Cross-reference 78.4(3)*"d"*)

f. Endodontic retreatment of a tooth will be authorized when the conventional treatment has been completed, a reasonable time has elapsed, and failure has been demonstrated with a radiograph and narrative history.

78.28(3) Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

a. A second lens correction within a 24-month period for members eight years of age and older. Payment shall be made when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross-references 78.6(4), 441—78.7(249A), and 78.1(18))

78.28(4) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person's hearing that would require a different hearing aid. (Cross-reference 78.14(7)*"d"*(1))

b. A hearing aid costing more than $650. The department shall approve payment for either of the following purposes (Cross-reference 78.14(7)*"d"*(2)):

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(5) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross-reference 441—78.1(249A))

b. All inpatient hospital admissions are subject to preadmission review. Payment for inpatient hospital admissions is approved when it meets the criteria for inpatient hospital care as determined by the IFMC or its delegated hospitals. Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 441—78.3(249A))

c. Preprocedure review by the IFMC is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the criteria established by the department and IFMC. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

78.28(6) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

b. Preprocedure review by the IFMC is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the IFMC and the department. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

78.28(7) All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

a. Approval shall be granted if ACT services are determined to be medically necessary. Approval shall be limited to no more than 180 days.

b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

78.28(8) Rescinded IAB 1/3/96, effective 3/1/96.

78.28(9) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in

the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.9(10))

78.28(10) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross-reference 78.10(3)*"b"*)

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09; **ARC 8714B**, IAB 5/5/10, effective 5/1/10; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9702B**, IAB 9/7/11, effective 9/1/11; **ARC 9883B**, IAB 11/30/11, effective 1/4/12]

441—78.29(249A) Behavioral health services. Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner's scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) *Limitations.*

a. An assessment and a treatment plan are required.

b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) *Exclusions.* Payment will not be approved for the following services:

a. Services provided in a medical institution.

b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.

c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) *Payment.*

a. Payment shall be made only for time spent in face-to-face consultation with the member.

b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9649B**, IAB 8/10/11, effective 8/1/11]

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services.

78.30(1) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.30(2) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) program, a birth center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.31(249A) Hospital outpatient services.

78.31(1) *Covered hospital outpatient services.* Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs *"g"* to *"m"* are subject to a random sample retrospective review for medical necessity by the Iowa Foundation for Medical Care. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs *"a"* to *"f"* shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs *"g"* to *"m"* shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

a. Emergency service.
b. Outpatient surgery.
c. Laboratory, X-ray and other diagnostic services.
d. General or family medicine.
e. Follow-up or after-care specialty clinics.
f. Physical medicine and rehabilitation.
g. Alcoholism and substance abuse.
h. Eating disorders.
i. Cardiac rehabilitation.
j. Mental health.
k. Pain management.
l. Diabetic education.
m. Pulmonary rehabilitation.
n. Nutritional counseling for persons aged 20 and under.

78.31(2) *Requirements for all outpatient services.*

a. Need for service. It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. Professional direction. All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. Goals and objectives. The goals and objectives of the program must be clearly stated. Paragraphs *"d"* and *"f"* and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. Treatment modalities used. The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. Criteria for selection and continuing treatment of patients. The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. Length of program. There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. Monitoring of services. The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

h. *Vaccines.* In order to be paid for the outpatient administration of a vaccine covered under the Vaccines for Children (VFC) program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.31(3) *Application for certification.* Hospital outpatient programs listed in subrule 78.31(1), paragraphs *"g"* to *"m,"* must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff's relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) *Requirements for specific types of service.*

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient's dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa, bulimia, or bulimarexia. Compulsive overeaters are not acceptable for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia as established by the DSM III R (Diagnostic and Statistical Manual, Third Edition, Revised).

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational

or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, mallery-weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

Ear, nose, and throat factors including headaches or dizziness.

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs shall be documented.

The patient's participation in the development of the treatment plans is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance abuse patients in subrule 78.31(3), paragraph *"a,"* subparagraph (6).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac disrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.

A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

Referral form.

Physician's orders.

Laboratory reports.

Electrocardiogram reports.

History and physical examination.

Angiogram report, if applicable.

Operative report, if applicable.

Preadmission interview.

Exercise prescription.

Rehabilitation plan, including participant's goals.

Documentation for exercise sessions and progress notes.

Nurse's progress reports.

Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, disrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of mental health problems.

The patient's educational level, vocational status, and job performance history.

The patient's social support network, including family and peer relationship.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational or vocational interests and hobbies.

The patient's ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient's written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs

are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge. A complete diabetic education program is payable once in the lifetime of a recipient.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

A diagnostic workup which entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician's order to participate anyway.

Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

Patients are reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations, respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

h. Nutritional counseling. Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a hospital for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.31(5) *Services rendered by advanced registered nurse practitioners certified in family, pediatric, or psychiatric mental health specialties and employed by a hospital.* Rescinded IAB 10/15/03, effective 12/1/03.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

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 mental retardation, 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]

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to clients eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.34(1) *Homemaker services.* Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and include:

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 client, and dishes.

c. Rescinded IAB 9/30/92, effective 12/1/92.

d. 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 a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). 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 one hour.

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 rule 441—83.1(249A).

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.

78.34(6) *Counseling services.* Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client 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 client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. 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.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes 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.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure 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.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, 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.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 one-hour units of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is one hour.

78.34(9) *Home and vehicle modification.* Covered home and 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 and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

(1) Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service.

(2) The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.34(10) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The required components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.34(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS ill and handicapped waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.34(13)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)*"b"*(3).

(6) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph 78.34(13)*"b"*(2) or the utilization adjustment factor in subparagraph 78.34(13)*"b"*(3). Anticipated costs for home and vehicle modification shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled

as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.

18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13)*"d."* The savings plan shall meet the requirements in paragraph 78.34(13)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,

2. Be medically necessary, and

3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

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]

441—78.35(249A) Occupational therapist services. Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4.

441—78.36(249A) Hospice services.

78.36(1) *General characteristics.* A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual

regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

(1) Nursing care.

(2) Medical social services.

(3) Physician services.

(4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.

(5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.

(6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

(7) Homemaker and home health aide services.

(8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.

(9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) *Approval for hospice benefits.* Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. Physician certification process. The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. Election procedures. Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.
4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

This rule is intended to implement Iowa Code section 249A.4.

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to consumers eligible for the HCBS elderly waiver services as established in 441—Chapter 83. The consumer shall have a billable waiver service each calendar quarter. Services must be billed in whole units.

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 a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). 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 client lives alone or when the person who usually performs these functions for the client is incapacitated or occupied providing direct care to the client. A unit of service is one hour. Components of the service include:

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, and washing and mending clothes.

c. Accompaniment to medical or psychiatric services.

d. Meal preparation: planning and preparing balanced meals.

e. Bathing and dressing for self-directing recipients.

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 one hour.

d. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.21(249A).

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

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 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.

78.37(7) *Chore services.* Chore services include the following services: window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows; minor repairs to walls, floors, stairs, railings and handles; heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care or painting and trash removal; and yard work such as mowing lawns, raking leaves and shoveling walks. A unit of service is one-half hour.

78.37(8) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.37(9) *Home and vehicle modification.* Covered home and 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 and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and 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 recipients to conduct business errands, essential shopping, to receive medical services not reimbursed through medical transportation, and to reduce social isolation. A unit of service is per mile, per trip, or rate established by area agency on aging.

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 one hour.

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.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes 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.

c. A unit of service provided by an individual or an agency, other than an assisted living program, is 1 hour or one 8- to 24-hour day. When provided by an assisted living program, a unit of service is one calendar month. If services are provided by an assisted living program for less than one full calendar month, the monthly reimbursement rate shall be prorated based on the number of days

service is provided. Except for services provided by an assisted living program, each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care on behalf of the member or on behalf of the provider.

g. The member, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure 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.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, 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.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a guardian if the guardian has given advanced direction for the service provision.

78.37(16) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.
2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.

8. Senior companion.

9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.37(16)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.37(16)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.37(16)*"b"*(3).

(6) Anticipated costs for home and vehicle modification and assistive devices are not subject to the average cost in subparagraph 78.37(16)*"b"*(2) or the utilization adjustment factor in subparagraph 78.37(16)*"b"*(3). Anticipated costs for home and vehicle modification and assistive devices shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and assistive devices may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.

2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.

3. Be accommodated within the member's budget without compromising the member's health and safety.

4. Be provided to the member or directed exclusively toward the benefit of the member.

5. Be the least costly to meet the member's needs.

6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.37(16)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or assistive device. When authorized, the budget may include an amount allocated for a home or vehicle modification or an assistive device. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or device.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.37(16)*"d."* The savings plan shall meet the requirements in paragraph 78.37(16)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,

2. Be medically necessary, and

3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.37(17) *Case management services.* Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

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]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to clients eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.38(1) *Counseling services.* Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client 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 client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. 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 client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and are:

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 client, and dishes.

c. Accompaniment to medical or psychiatric services or for children aged 18 and under to school.

d. 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 one hour.

d. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.41(249A).

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

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 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.

78.38(6) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.38(7) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). 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.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes 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.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure 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.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, 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.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.38(9) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.38(9)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.38(9)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.38(9)*"b"*(3).

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.

3. Be accommodated within the member's budget without compromising the member's health and safety.

4. Be provided to the member or directed exclusively toward the benefit of the member.

5. Be the least costly to meet the member's needs.

6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.38(9)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.

2. Clothing not related to an assessed medical need.

3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.

4. Costs associated with shipping items to the member.

5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.

7. Home furnishings.

8. Home repairs or home maintenance.

9. Homeopathic treatments.

10. Insurance premiums or copayments.

11. Items purchased on installment payments.

12. Motorized vehicles.

13. Nutritional supplements.

14. Personal entertainment items.

15. Repairs and maintenance of motor vehicles.

16. Room and board, including rent or mortgage payments.

17. School tuition.

18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.38(9)*"d."* The savings plan shall meet the requirements in paragraph 78.38(9)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

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)]

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. All services include the applicable and necessary instruction, supervision, assistance and support as required by the member in achieving the member's life goals. The services, amount and supports provided under the HCBS intellectual disability waiver shall be delivered in the least restrictive environment and in conformity with the member's service plan. Reimbursement shall not be available under the waiver for any services that the member can obtain through the Medicaid state plan. All services shall be billed in whole units.

78.41(1) *Supported community living services.* Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities.

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) One hour 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) 5,110 hourly units are available per state fiscal year except a leap year when 5,124 hourly 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 one hour.

d. Payment for respite services shall not exceed $7,050 per the member's waiver year.

e. The service shall be identified in the member's individual comprehensive plan.

f. Respite services shall not be simultaneously reimbursed with other residential or respite services or with supported community living, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

g. 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.

h. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.60(249A).

i. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

j. 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.

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 and 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 and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.41(5) *Nursing services.* Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) *Home health aide services.* Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the member's service plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) *Supported employment services.* Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs *"a"* and *"b"* that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a consumer for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the consumer and the interdisciplinary team described in 441—subrule 83.67(1) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the consumer's interdisciplinary team must determine that the identified services are necessary. Third, the consumer's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the consumer holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A consumer may receive two units of job development services during a 12-month period. The activities provided to the consumer may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.

2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.

3. Customized job development services specific to the consumer.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining consumers in their workforce and to communicate expectations of the employers to the interdisciplinary team described in 441—subrule 83.67(1). Employer development services may be provided only to consumers who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the consumer holds for 30 consecutive calendar days or more. Payment for this service may be made only after the consumer holds the job for 30 days. A consumer may receive two units of employer development services during a 12-month period if the consumer is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual consumers when appropriate.

2. Job analysis for a specific job.

3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.

4. Identifying and arranging reasonable accommodations with the employer.

5. Providing disability awareness and training to the employer when it is deemed necessary.

6. Providing technical assistance to the employer regarding the training progress as identified on the consumer's customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided for a minimum of 30 days or with assisting the consumer in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the consumer's employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the consumer.

2. Assistance with applying for a job, including completion of applications or interviews.

3. Work site assessment and job accommodation evaluation.

b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the consumer associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.

2. Job coaching.

3. On-the-job or work-related crisis intervention.

4. Assisting the consumer to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.

5. Consumer-directed attendant care services as defined in subrule 78.41(8).

6. Assistance with time management.

7. Assistance with appropriate grooming.

8. Employment-related supportive contacts.

9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.

10. On-site vocational assessment after employment.

11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining consumers in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.

(3) A unit of service is one hour.

(4) A maximum of 40 units may be received per week.

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the consumer within the performance of the consumer's job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the

consumer must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each consumer.

(6) All services shall be identified in the consumer's service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining consumers in day activity programs, work activity programs or sheltered workshop programs;
2. Supports for volunteer work or unpaid internships;
3. Tuition for education or vocational training; or
4. Individual advocacy that is not consumer specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.41(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed

nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes 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.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure 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.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, 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.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.41(9) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 one-hour units of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is one hour.

78.41(10) *Residential-based supported community living services.* Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)*"d."*

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS intellectual disability waiver supported community living service.

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. A unit of service is a full day (4 to 8 hours) or a half-day (1 to 4 hours) or an extended day (8 to 12 hours).

78.41(13) *Prevocational services.* Prevocational services are services that are aimed at preparing a member for paid or unpaid employment, but that are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities that are not primarily directed at teaching specific job skills but at more generalized habilitative goals, and are reflected in a habilitative plan that focuses on general habilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) that are otherwise available to the member through a state or local education agency.

(2) Vocational rehabilitation services that are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

c. A unit of service is a full day (4 to 8 hours), a half day (1 to 4 hours), or an hour.

78.41(14) *Day habilitation services.*

a. Scope. Day habilitation services are services that assist or support the consumer in developing or maintaining life skills and community integration. Services must enable or enhance the consumer's intellectual functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

b. Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the consumer's home. The unit of service is an hour. The units of services payable are limited to a maximum of 10 hours per month.

c. Unit of service. Except as provided in paragraph *"b,"* the unit of service may be an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

d. Exclusions.

(1) Services shall not be provided in the consumer's home, except as provided in paragraph *"b."* For this purpose, services provided in a residential care facility where the consumer lives are not considered to be provided in the consumer's home.

(2) Services shall not include vocational or prevocational services and shall not involve paid work.

(3) Services shall not duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(4) Services shall not be provided simultaneously with other Medicaid-funded services.

78.41(15) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disabilities waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.41(15)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.41(15)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.41(15)*"b"*(3).

(6) Anticipated costs for home and vehicle modification and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.41(15)*"b"*(2) or the utilization adjustment factor in subparagraph 78.41(15)*"b"*(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Costs for home and vehicle modification and supported employment services to obtain a job may be paid to the financial management services provider in a one-time payment. Before becoming part of the individual budget, all home and vehicle modifications and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.41(15)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.41(15)*"d."* The savings plan shall meet the requirements in paragraph 78.41(15)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

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]

441—78.42(249A) Pharmacies administering influenza vaccine to children. Payment will be made to a pharmacy for the administration of influenza vaccine available through the Vaccines for Children (VFC) program administered by the department of public health if the pharmacy is enrolled in the VFC program. Payment will be made for the vaccine only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9132B**, IAB 10/6/10, effective 11/1/10; **ARC 9316B**, IAB 12/29/10, effective 2/2/11; **ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to consumers eligible for the HCBS brain injury services as established in 441—Chapter 83 and as identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the service plan. The services, amount and supports provided under the HCBS brain injury waiver shall be delivered in the least restrictive environment and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid.

All services shall be billed in whole units.

78.43(1) *Case management services.* Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. Members who are at the ICF/MR level of care whose county has voluntarily chosen to participate in the HCBS brain injury waiver are eligible for targeted case management and, therefore, are not eligible for case management as a waiver service.

78.43(2) *Supported community living services.* Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from work or day programs.

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at an hourly 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) One hour 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) 8,395 hourly units are available per state fiscal year except a leap year, when 8,418 hourly 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 one hour.

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. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS brain injury waiver supported community living services, Medicaid nursing, or Medicaid home health aide services.

f. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.81(249A).

g. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

h. 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.

78.43(4) *Supported employment services.* Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs *"a"* and *"b"* that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a consumer for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the consumer and the interdisciplinary team described in rule 441—83.87(249A) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet the consumer's employment needs. Second, the consumer's interdisciplinary team must determine that the identified services are necessary. Third, the consumer's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the consumer holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A consumer may receive two units of job development services during a 12-month period. The activities provided to the consumer may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.
2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.
3. Customized job development services specific to the consumer.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining consumers in their workforce and to communicate expectations of the employers to the interdisciplinary team described in rule 441—83.87(249A). Employer development services may be provided only to consumers who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the consumer holds for 30 consecutive calendar days or more. Payment for this service may be made only after the consumer holds the job for 30 days. A consumer may receive two units of employer development services during a 12-month period if the consumer is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual consumers when appropriate.
2. Job analysis for a specific job.
3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.
4. Identifying and arranging reasonable accommodations with the employer.
5. Providing disability awareness and training to the employer when it is deemed necessary.
6. Providing technical assistance to the employer regarding the training progress as identified on the consumer's customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the consumer for a minimum of 30 days or with assisting the consumer in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the consumer's employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the consumer.
2. Assistance with applying for a job, including completion of applications or interviews.

3. Work site assessment and job accommodation evaluation.

b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the consumer associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assisting the consumer to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Consumer-directed attendant care services as defined in subrule 78.43(13).
6. Assistance with time management.
7. Assistance with appropriate grooming.
8. Employment-related supportive contacts.
9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.
10. On-site vocational assessment after employment.
11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining consumers in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.

(3) A unit of service is one hour.

(4) A maximum of 40 units may be received per week.

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the consumer within the performance of the consumer's job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each consumer.

(6) All services shall be identified in the consumer's service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining consumers in day activity programs, work activity programs or sheltered workshop programs;
2. Supports for volunteer work or unpaid internships;
3. Tuition for education or vocational training; or
4. Individual advocacy that is not consumer specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other

Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.43(5) *Home and vehicle modification.* Covered home and 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 and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service. The case

manager or service worker may encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.43(6) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.43(7) *Transportation.* Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service.

78.43(8) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:

(1) Provide for health and safety of the member,

(2) Are not ordinarily covered by Medicaid,

(3) Are not funded by educational or vocational rehabilitation programs, and

(4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

(1) Electronic aids and organizers.

(2) Medicine dispensing devices.

(3) Communication devices.

(4) Bath aids.

(5) Noncovered environmental control units.

(6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to $6,060 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

(1) Documented by a health care professional as necessary for the member's health and safety, and

(2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.43(9) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a full day (4 to 8 hours) or a half day (1 to 4 hours) or an extended day (8 to 12 hours). Components of the service include health-related care, social services, and other related support services.

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) *Prevocational services.* Prevocational services are services which are aimed at preparing a member for paid or unpaid employment, but which are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities which are not primarily directed at teaching specific job skills but at more generalized habilitative goals and are reflected in a habilitative plan which focuses on general habilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) which are otherwise available to the member through a state or local education agency, or

(2) Vocational rehabilitation services which are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

c. A unit of service is a full day (4 to 8 hours), a half day (1 to 4 hours), or an hour.

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.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy.

(9) Care of medical conditions out of control which includes 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.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure 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.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, 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.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.43(14) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 one-hour units of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is one hour.

78.43(15) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Specialized medical equipment.
7. Supported community living.
8. Supported employment.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.43(15)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.43(15)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.43(15)*"b"*(3).

(6) Anticipated costs for home and vehicle modification, specialized medical equipment, and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.43(15)*"b"*(2) or the utilization adjustment factor in subparagraph 78.43(15)*"b"*(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications, specialized medical equipment, and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker. Costs for these services may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.43(15)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.43(15)*"d."* The savings plan shall meet the requirements in paragraph 78.43(15)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

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]

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

This rule is intended to implement Iowa Code section 249A.4.

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

78.45(1) *Applicability.* ACT services may be provided only to a member who meets all of the following criteria:

a. The member is at least 17 years old.

b. The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:

(1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;

(2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and

(3) The member exhibits significant impairment in social, interpersonal, or familial functioning.

c. The member has a validated principal DSM-IV-TR Axis I diagnosis consistent with a severe and persistent mental illness. Members with a primary diagnosis of substance disorder, developmental disability, or organic disorder are not eligible for ACT services.

d. The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

(1) Is medically stable;

(2) Does not require a level of care that includes more intensive medical monitoring;

(3) Presents a low risk to self, others, or property, with treatment and support; and

(4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

(1) Treatment objectives and outcomes,

(2) The expected frequency and duration of each service,

(3) The location where the services will be provided,

(4) A crisis plan, and

(5) The schedule for updates of the treatment plan.

78.45(2) *Services.* The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. Evaluation and medication management.

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. Integrated therapy and counseling for mental health and substance abuse. This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. Skill teaching. Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

d. Community support. Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. Medication monitoring. Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

(1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and

(2) Ensuring that the member keeps appointments.

f. Case management for treatment and service plan coordination. Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the member in gaining access to necessary medical, social, educational, and other services.

3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.

2. Make referrals to services and related activities to assist the member with the assessed needs.

3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.

4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

g. Crisis response. Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

h. Work-related services. Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

(1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.

(2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.

(3) Providing supports to maintain employment, such as crisis intervention related to employment.

(4) Teaching communication, problem solving, and safety skills.

(5) Teaching personal skills such as time management and appropriate grooming for employment.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11]

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to consumers eligible for the HCBS physical disability waiver established in 441—Chapter 83 when identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the service plan and those delineated in Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. The service shall be delivered in the least restrictive environment consistent with the consumer's needs and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid or from any other funding source.

All services shall be billed in whole units as specified in the following subrules.

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. The services must be cost-effective and necessary to prevent institutionalization.

a. Providers must demonstrate proficiency in delivery of the services in the member's plan of care. Proficiency must be demonstrated through documentation of prior training or experience or a certificate of formal training.

(1) All training or experience will be detailed on Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, which must be reviewed and approved by the service worker for appropriateness of training or experience prior to the provision of services. Form 470-3372 becomes an attachment to and part of the case plan.

(2) The member shall give direction and training for activities which are not medical in nature to maintain independence. Licensed registered nurses and therapists must provide on-the-job training and supervision to the provider for skilled activities listed below and described on Form 470-3372. The training and experience must be sufficient to protect the health, welfare and safety of the member.

b. Nonskilled service activities covered are:

(1) Help with dressing.

(2) Help with bath, shampoo, hygiene, and grooming.

(3) Help with access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance which includes emptying the catheter bag, collecting a specimen and cleaning the external area around the catheter. Certification of training which includes demonstration of competence for catheter assistance is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Help with medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. Certification of training in a medication aide course is available through the area community colleges.

(8) Minor wound care which does not require skilled nursing care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistance in use of assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

c. Skilled service activities covered are the following performed under the supervision of a licensed nurse or licensed therapist working under the direction of a licensed physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall not be included in the reimbursement for consumer-directed attendant care services.

(1) Tube feedings of members unable to eat solid foods.

(2) Assistance with intravenous therapy which is 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 bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions such as brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nurse-delegated activities under the supervision of the registered nurse.

(11) Monitoring medication reactions 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.

d. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

e. The member, guardian, or attorney in fact under a durable power of attorney for health care shall:

(1) Select the person or agency that will provide the components of the attendant care services.

(2) Determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care on behalf of the member or on behalf of the provider.

g. The member, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure 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.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, 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.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a guardian if the guardian has given advanced direction for the service provision.

78.46(2) *Home and vehicle modification.* Covered home and 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 and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service. The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.46(3) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.46(4) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:

(1) Provide for the health and safety of the member,

(2) Are not ordinarily covered by Medicaid,

(3) Are not funded by educational or vocational rehabilitation programs, and

(4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

(1) Electronic aids and organizers.

(2) Medicine dispensing devices.

(3) Communication devices.

(4) Bath aids.

(5) Noncovered environmental control units.

(6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to $6,060 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

(1) Documented by a health care professional as necessary for the member's health and safety, and

(2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.46(5) *Transportation.* Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through Medicaid as medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging.

78.46(6) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Specialized medical equipment.
4. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.46(6)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.46(6)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.46(6)*"b"*(3).

(6) Anticipated costs for home and vehicle modification and specialized medical equipment are not subject to the average cost in subparagraph 78.46(6)*"b"*(2) or the utilization adjustment factor in subparagraph 78.46(6)*"b"*(3). Anticipated costs for home and vehicle modification and specialized medical equipment shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and specialized medical equipment may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.46(6)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and

approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.46(6)*"d."* The savings plan shall meet the requirements in paragraph 78.46(6)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for waiver goods and services optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.
(2) Select employees from a worker registry.
(3) Verify employee qualifications.
(4) Specify additional employee qualifications.
(5) Determine employee duties.
(6) Determine employee wages and benefits.
(7) Schedule employees.
(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

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]

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) Rehabilitation services for adults with chronic mental illness. Rescinded IAB 8/1/07, effective 9/5/07.

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 consumers eligible for the HCBS children's mental health waiver as established in 441—Chapter 83. All services shall be provided in accordance with the general standards in subrule 78.52(1), as well as standards provided specific to each waiver service in subrules 78.52(2) through 78.52(5).

78.52(1) *General service standards.* All children's mental health waiver services shall be provided in accordance with the following standards:

a. Services must be based on the consumer's needs as identified in the consumer's service plan developed pursuant to 441—83.127(249A).

(1) Services must be delivered in the least restrictive environment consistent with the consumer's needs.

(2) Services must include the applicable and necessary instruction, supervision, assistance and support as required by the consumer to achieve the consumer's goals.

b. Payment for services shall be made only upon departmental approval of the services. Waiver services provided before approval of the consumer's eligibility for the waiver shall not be paid.

c. Services or service components must not be duplicative.

(1) Reimbursement shall not be available under the waiver for any services that the consumer may obtain through the Iowa Medicaid program outside of the waiver.

(2) Reimbursement shall not be available under the waiver for any services that the consumer may obtain through natural supports or community resources.

(3) Services may not be simultaneously reimbursed for the same period as nonwaiver Medicaid services or other Medicaid waiver services.

(4) Costs for waiver services are not reimbursable while the consumer is in a medical institution.

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 consumer and the consumer'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 consumer's and the family's social and emotional strength.

a. Dependent on the needs of the consumer and the consumer's family members individually or collectively, family and community support services may be provided to the consumer, to the consumer's family members, or to the consumer 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 consumer's interdisciplinary team pursuant to 441—83.127(249A).

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 consumer and for the consumer's family.

(2) Modeling and coaching effective coping strategies for the consumer's family members.

(3) Building resilience to the stigma of serious emotional disturbance for the consumer 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 consumer's crisis intervention plan as defined in 441—24.1(225C) for life situations with the consumer's family and in the community.

(6) Developing medication management skills.

(7) Developing personal hygiene and grooming skills that contribute to the consumer'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 consumer 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 identify the transportation or therapeutic resource as a support need.

(2) The annual amount available for transportation and therapeutic resources must be listed in the consumer's service plan.

(3) The consumer's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the consumer or the consumer's family or legal guardian.

(4) The consumer's Medicaid targeted 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.

(6) Family and community support services providers shall maintain records to:

1. Ensure that the transportation and therapeutic resources provided to not exceed the maximum amount authorized; and

2. Support the annual reporting requirements in 441—subparagraph 79.1(15)*"a"*(1).

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 consumer care.

f. A unit of family and community support services is one hour.

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the consumer 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 consumer to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through the Iowa Plan or other funding sources.

c. A unit of in-home family therapy service is one hour. Any period less than one hour shall be prorated.

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 "usual caregiver" means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

a. Respite care shall not 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.

b. The usual caregiver cannot be absent from the home for more than 14 consecutive days during respite provision.

c. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team. The team shall determine the type of respite care to be provided according to these definitions:

(1) Basic individual respite is provided on a ratio of one staff to one member. The member does not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

(2) Specialized respite is provided on a ratio of one or more nursing staff to one member. The member has specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

(3) Group respite is provided on a ratio of one staff to two or more members receiving respite. These members do not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

d. 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.

e. 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.

f. A unit of service is one hour.

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]

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641—8.1(135) Definitions. For purposes of this chapter, the following definitions apply:

"Abnormal screen" means a suspicion of breast or cervical cancer or laboratory values of total cholesterol or blood glucose and average blood pressure reading in the range defined by the CDC according to National Heart, Lung and Blood Institute guidelines.

1. A suspicion of breast cancer includes clinical breast examination findings of: palpable breast mass, breast dimpling, nipple retraction, bloody nipple discharge, palpable lymph nodes around clavicle or axilla, nipple erythema and scaliness, a mammography result of breast imaging reporting and data systems (BI-RADS) category 4 (suspicious abnormality suggesting need for biopsy) or category 5 (highly suggestive of malignancy) (ICD-9 793.8), breast biopsy result of ductal cancer in situ, lobular cancer in situ (ICD-9 233.0), or breast or lymph node (or other) biopsy result of breast cancer.

2. Suspicion of cervical cancer is a Pap test result of atypical squamous cells cannot exclude high-grade squamous intraepithelial lesions (ASC-H) (ICD-9 795.02), atypical glandular cells (AGC) (ICD-9 795.00), low-grade squamous intraepithelial lesions (LSIL) (ICD-9 622.11 or 795.03), or high-grade squamous intraepithelial lesions (HSIL) (ICD-9 622.12 or 795.04), leukoplakia of the cervix (ICD-9 622.2), or cervical biopsy result of cervical intraepithelial neoplasia II or III (ICD-9 622.10, 622.11, 622.12, 795.03, or 795.04), or cancer in situ (ICD-9 233.1).

3. Abnormal value means laboratory values of total cholesterol or blood glucose (HbA1c if diagnosed diabetic) and average blood pressure reading in the range defined by the CDC according to National Heart, Lung and Blood Institute guidelines.

"ACR" or *"American College of Radiology"* means one of the Food and Drug Administration-recognized accreditation bodies for minimum quality standards for personnel, equipment, and record keeping in facilities that provide mammography.

"Advanced registered nurse practitioner" means an individual licensed to practice under 655—Chapter 7.

"Alert value" means laboratory values of total cholesterol or blood glucose and average blood pressure reading in the range defined by the CDC according to National Heart, Lung and Blood Institute guidelines.

"BCCPTA" or *"Breast and Cervical Cancer Prevention and Treatment Act of 2000"* means a federal law that provides each state with the option of extending Medicaid eligibility to women who were diagnosed with breast or cervical cancer through the National Breast and Cervical Cancer Early Detection Program.

"BCCT option of Medicaid" or *"breast and cervical cancer treatment option of Medicaid"* means the optional program of medical aid designed for women who are unable to afford regular medical service and are diagnosed with breast or cervical cancer through the National Breast and Cervical Cancer Early Detection Program or through funds from Susan G. Komen for the Cure. The BCCT option of Medicaid is financed by federal and state payment sources and is authorized by Title XIX of the Social Security Act.

"Benign" means a noncancerous condition that does not spread to other parts of the body.

"Biopsy" means the removal of a sample or an entire abnormality for microscopic examination to diagnose a problem. Examples of a sampling would be a core biopsy or incisional biopsy; an example of entire removal would be an excisional biopsy.

"BI-RADS" or *"breast imaging reporting and data systems"* means a standardized reporting system for mammography reports.

"Blood pressure" means the pressure or tension of the blood within the systemic arteries, maintained by the contraction of the left ventricle, the resistance of the arterioles and capillaries, the elasticity of the arterial walls, as well as the viscosity and volume of the blood; expressed as relative to the ambient atmospheric pressure.

"BMI" or *"body-mass index"* means a number calculated from a person's weight and height. BMI provides a reliable indicator of body fatness for most people and is used to screen for weight categories that may lead to health problems.

"Breast ultrasound" means the use of high-energy sound waves that are bounced off internal tissues and make echoes to produce a pictorial representation of the internal structure of the breast.

"Cancer" means a malignant tumor of potentially unlimited growth of new cells that expand locally by invasion and systemically by metastasis.

"Carcinoma in situ" means cell changes in which malignant cells are localized and may press against adjoining tissue but have not penetrated or spread beyond their site of origin.

"Cardiologist" means a physician who specializes in the study of the heart and its action and diseases.

"Case management" means the IA CFY program component that involves establishing, brokering, and sustaining a system of available clinical and essential support services for all women enrolled in the program.

"CBE" or *"clinical breast examination"* means complete examination of a woman's breast and axilla with palpation by a health care provider, including examination of the breast in both the upright and supine positions.

"CDC" means the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.

"Cholesterol" means a waxy, fat-like substance made in the liver and other cells and found in certain foods, such as foods from animals, for example, dairy products, eggs and meat. Types of cholesterol are as follows:

1. Low density lipoprotein or LDL, also called "bad" cholesterol. LDL can cause buildup of plaque on the walls of arteries. The more LDL there is in the blood, the greater the risk of heart disease.
2. High density lipoprotein or HDL, also called "good" cholesterol. HDL helps the body get rid of bad cholesterol in the blood. If levels of HDL are low, risk of heart disease increases.
3. Very low density lipoprotein or VLDL. VLDL is similar to LDL cholesterol in that it contains mostly fat and not much protein.

"CLIA" or *"Clinical Laboratory Improvement Act of 1988"* means the law which established minimum quality standards for personnel and quality assurance methods that monitor patient test management and assess quality control, proficiency testing, and personnel handling of laboratory and pathology specimens.

"CLIA-waived tests" means simple laboratory examinations and procedures that are cleared by the federal government for home use; that employ methodologies that are so simple and accurate that erroneous results would be negligible; or that pose no reasonable risk of harm to the patient if the test is performed incorrectly.

"Colposcopy" means a procedure that allows close examination of the surface of the cervix with a high-powered microscope.

"Community referral" means the act, action or instance of directing a participant to a community resource.

"Community resource" means a source of information, service or expertise that is available within the community.

"Cooperative agreement" means a signed contract between the department and another party, for example, a health care provider. This contract allows the department to pay the health care provider for providing services to IA CFY program participants.

"Creditable coverage" means any insurance that pays for medical bills incurred for the screening, diagnosis, or treatment of breast and cervical cancer. Creditable coverage as described by the Health Insurance Portability and Accountability Act of 1996 includes, but is not limited to, group health plans or health insurance coverage consisting of medical care under any hospital or medical service policy, health maintenance organization, Medicare Part A or B, Medicaid, armed forces insurance, or state health risk pool. A woman who has creditable coverage shall not be eligible for coverage under the breast and cervical cancer treatment option of Medicaid.

"Creditable coverage circumstances" means those instances in which a woman has creditable coverage but is not actually covered for treatment of breast or cervical cancer.

1. When there is a preexisting-condition exclusion or when the annual or lifetime limit on benefits has been exhausted, a woman is not considered to have creditable coverage for this treatment.
2. If the woman has limited coverage, such as a high deductible, limited drug coverage, or a limited number of outpatient visits, she is still considered to have creditable coverage and is not eligible for coverage under the breast and cervical cancer treatment option of Medicaid.
3. If the woman has a policy with a limited scope of coverage, such as only dental, vision, or long-term care, or has a policy that covers only a specific disease or illness, she is not considered to have creditable coverage unless the policy provides coverage for breast and cervical cancer treatment.
4. For the purposes of this program, eligibility for Indian Health Services or tribal health care is not considered creditable coverage (according to P.L. 107-121, the Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2001).

"Cytology" means the scientific study of cells.

"Cytopathology" means the scientific study of cells in disease.

"Cytotechnologist" means a medical technician trained in the identification of cells and cellular abnormalities.

"Department" means the Iowa department of public health.

"Diagnostic mammography" means a radiological examination performed for appropriate clinical indications, such as breast mass(es), other breast signs or symptoms (spontaneous nipple discharge, skin changes), or special cases, such as a history of breast cancer with breast conservation or augmented breasts.

"FDA" or *"Food and Drug Administration"* means the federal governmental body which certifies that a mammography facility meets minimum quality standards for personnel, equipment, and record keeping.

"Follow-up" means the IA CFY program component that involves a system for seeking information about or reviewing an abnormal condition, rescreening, or recall for annual visits.

"Glucose" means a simple sugar that is an important carbohydrate in biology. Cells use glucose as a source of energy and a metabolic intermediate.

"Gynecologist" means a physician who specializes in diseases of the reproductive organs in women.

"HbA1c" or *"glycosylated hemoglobin"* means a clinical laboratory test for the purposes of monitoring blood glucose control of a participant diagnosed with diabetes.

"Health care provider" means any physician, advanced registered nurse practitioner, or physician assistant who is licensed by the state of Iowa and provides care to IA CFY program-enrolled women.

"Heart disease" means a broad term used to describe a range of diseases that affect the heart and, in some cases, blood vessels. The term is often used interchangeably with "cardiovascular disease," which generally refers to conditions that involve narrowed or blocked blood vessels that can lead to a heart attack, chest pain (angina) or stroke.

"Heart disease risk factors" means identifiable factors that make some people more susceptible than others to heart disease. Heart disease risk factors include:

1. Being overweight.
2. Lack of physical activity.
3. High blood pressure.
4. High blood cholesterol.
5. Diabetes.
6. Cigarette smoking.

Risk factors that cannot be changed are age and family history. The more heart disease risk factors a person has increases the person's chance of developing heart disease.

"IA BCCEDP" or *"Iowa breast and cervical cancer early detection program"* means a comprehensive breast and cervical cancer screening program established and funded under Title XV of the federal Public Health Service Act and administered by the Iowa department of public health,

with the delegated responsibility of implementation and evaluation from the CDC, Division of Cancer Prevention and Control.

"IA CFY program" or *"Iowa care for yourself program"* means an integrated comprehensive breast and cervical cancer screening program and cardiovascular risk factor screening and intervention program administered by the Iowa department of public health.

"IA WISEWOMAN" or *"Iowa well-integrated screening and evaluation for women across the nation"* means a cardiovascular-related risk factor screening and intervention program to provide standard preventive screening services, including blood pressure measurements, cholesterol testing, and lifestyle interventions that target poor nutrition, physical inactivity, and tobacco use. The program is authorized by the federal government and administered by the CDC to help reduce deaths and disability from heart disease and stroke.

"ICD-9" or *"International Classification of Disease, 9th edition"* means a standardized classification of diseases, injuries, and reasons of death, by cause and anatomic localization, which is systematically put into a number of up to six digits and which allows clinicians, statisticians, politicians, health planners and others to speak a common language, both in the United States and internationally.

"Infrastructure" means the basic framework of sufficient staff and adequate support systems to plan, implement, and evaluate the components of the IA CFY program.

"In need of treatment" means that a medical or surgical intervention is required because of an abnormal finding of breast or cervical cancer or precancer that was determined as a result of a screening or diagnostic procedure for breast or cervical cancer/precancer under the NBCCEDP.

"Intervention" means services that promote a heart-healthy diet and physical activity and that are based on screening results, which include blood pressure, cholesterol, glucose, weight, height, personal medical history, family medical history, and health behavior and readiness-to-change assessments.

"MATF" or *"medical advisory task force"* means an advisory board that may be utilized by the IA CFY program to offer knowledge and experience as related to the fields of expertise of the members of the task force. Duties of the MATF may include, but are not limited to, the following:

1. Reviewing and making recommendations for clinical service expansion.
2. Reviewing program-developed clinical protocols.
3. Providing recommendations related to other clinical and participant-related issues.
4. Providing input related to quality assurance issues.
5. Reviewing program screening and diagnostic data.

"MDEs" or *"minimum data elements"* means a set of standardized data elements used to collect demographic and clinical information on women whose screening or diagnosis was paid for with IA CFY program funds. MDEs were developed by the CDC, Division of Cancer Prevention and Control, to ensure that consistent and complete information is collected on women whose screening or diagnosis was paid for with IA CFY program funding.

"Medicaid" means the program of medical aid designed for those unable to afford regular medical service, financed by federal and state payment sources, and authorized by Title XIX of the Social Security Act.

"Medicare" means the program of federal payment source for health benefits, especially for the aged, which is authorized by Title XVIII of the Social Security Act.

"NBCCEDP" or *"National Breast and Cervical Cancer Early Detection Program"* means a program established with the passage of the Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law 101-354). The law authorizes the CDC to establish a program of grants to states, tribes, and territories for the purpose of increasing the early detection of breast and cervical cancer, particularly among low-income, uninsured, and underserved women.

"Oncologist" means a physician who is a specialist in treating or studying the physical, chemical, and biologic properties and features of neoplasms, including causation, pathogenesis, and treatment.

"Outreach" means the IA CFY program component that involves recruiting targeted populations or women who never or rarely utilize preventive health services.

"Pap test" means the Papanicolaou screening test that collects cells from the cervix for examination under a microscope. The Pap test can detect abnormal cells or precancerous cells before cancer develops.

"Pathologist" means a physician who is a specialist in identifying diseases by studying cells and tissues under a microscope.

"Physician" means an individual licensed to practice under Iowa Code chapter 148.

"Physician assistant" means an individual licensed to practice under Iowa Code chapter 148C.

"Precancerous" means a condition that may become, or is likely to become, cancer.

"Program and fiscal management" means the IA CFY program component that includes planning, organizing, directing, coordinating, managing, budgeting for, and evaluating program activities.

"Quitline Iowa" means a toll-free, statewide smoking cessation telephone counseling hotline through which trained counselors provide caller assistance in making an individualized tobacco use quit plan and provide ongoing support through optional follow-up calls.

"Radiologist" means a physician who specializes in creating and interpreting pictures of areas inside the body. The pictures are produced with X-rays, sound waves, or other types of energy.

"Rarely or never been screened" means, as defined for the NBCCEDP, that a woman has not had cervical cancer screening within the last five years or has never been screened for cervical cancer.

"Recruitment" means the IA CFY program component that involves enrolling targeted populations or women for preventive health services.

"Referral" means the IA CFY program component that involves directing women with abnormal screening results to appropriate resources for follow-up action.

"Screening mammography" means the use of X-ray of the breasts of asymptomatic women in an attempt to detect abnormal lesions of the breast when they are small, nonpalpable, and confined to the breast.

"Service delivery" means providing, either directly or through contractual arrangements, comprehensive breast and cervical cancer screening and heart disease and stroke risk factor screening, diagnosis, and treatment services through tracking of screening intervals, timeliness of diagnosis, and timeliness of treatment of women.

"Surgeon" means a physician who treats disease, injury, or deformity by physical operation or manipulation.

"Surveillance" means the IA CFY program component that involves the systematic collection, analysis, and interpretation of health data.

"Susan G. Komen for the Cure" means an international organization with a network of volunteers working through local affiliates and Komen Race for the Cure® events to eradicate breast cancer as a life-threatening disease by advancing research, education, screening, and treatment.

"TBS" or *"the Bethesda system"* means a system that was developed to provide uniform diagnostic terminology for reporting cervical or vaginal cytologic findings to facilitate communication between the laboratory and the clinician.

"Triglycerides" means a type of fat that is carried in the blood by very low density lipoproteins. Excess calories, alcohol, or sugar in the body are converted into triglycerides and stored in fat cells throughout the body.

"WISEWOMAN" or *"Well-Integrated Screening and Evaluation for Women Across the Nation"* means a national program that offers blood pressure, diabetes, and cholesterol risk factor screening, lifestyle intervention, and referral services in an effort to prevent cardiovascular disease.

[**ARC 0059C**, IAB 4/4/12, effective 5/9/12]

641—8.2(135) Components of the Iowa care for yourself (IA CFY) program. The IA CFY program shall include the following key components:

8.2(1) Program and fiscal management shall be conducted by ensuring strategic planning, implementation, coordination, integration, and evaluation of all programmatic activities and administrative systems, as well as the development of key communication channels and oversight mechanisms to aid in these processes. Program management shall ensure that infrastructure adequately supports service delivery.

8.2(2) Service delivery of specific and appropriate clinical procedures to detect breast and cervical abnormalities and heart disease or stroke risk factors for women enrolled in the IA CFY program shall be directly provided or provided through contractual arrangements.

a. The IA CFY program shall cover breast and cervical cancer screening and diagnostic services including, but not limited to, the following when those services are provided by a participating health care provider who has a cooperative agreement with the IA CFY program. Payment shall be based on Medicare Part B participating-provider rates as released annually at the beginning of each calendar year.

(1) Physical examinations that include two recorded blood pressures in addition to one or more of the following screening services: CBE, pelvic examination, or Pap test;

(2) Height and weight measurements, when provided in conjunction with one or more of the screening services listed in subparagraph 8.2(2)*"a"*(1) above;

(3) Mammography (screening and diagnostic);

(4) Breast ultrasound, when used as an adjunct to mammography;

(5) Fine-needle aspiration of breast cysts;

(6) Breast biopsies, excisional and nonexcisional (physician charges only; hospital charges are not covered);

(7) Colposcopy of the cervix, with or without biopsy;

(8) Surgical consultations for diagnosis of breast and cervical cancer;

(9) Pathology charges for breast and cervical biopsies;

(10) Anesthesia for breast biopsies (health care provider charges only; hospital charges and supplies are not covered).

b. Breast and cervical cancer-related services not covered by the IA CFY program include, but are not limited to, the following:

(1) Services not related to breast or cervical cancer screening or diagnosis;

(2) Treatment procedures and services;

(3) Services provided by nonparticipating providers;

(4) Hospital charges for breast biopsies and anesthesia;

(5) Inpatient services.

c. The IA CFY program shall cover cardiovascular disease-related services for those participants enrolled in the IA CFY program for whom at least one screening service was paid for using federal funds. Cardiovascular disease-related services shall include, but not be limited to, the following when those services are provided by a participating health care provider who has a cooperative agreement with the IA CFY program. Payment shall be based on Medicare Part B participating-provider rates as released annually at the beginning of each calendar year.

(1) Physical examinations that include two recorded blood pressures;

(2) Height and weight measurements;

(3) Fasting lipid panel that includes total cholesterol, HDL cholesterol, LDL cholesterol, triglycerides; and

(4) Diabetes screening:

1. For a nondiagnosed diabetic, fasting blood glucose; and

2. For a diagnosed diabetic, glycosylated hemoglobin (HbA1c).

d. Cardiovascular disease-related services not covered by the IA CFY program include, but are not limited to, the following:

(1) A follow-up diagnostic visit to a health care provider if one or more screening values are in the CDC-defined abnormal value range;

(2) Repeat laboratory testing;

(3) Any additional testing;

(4) Medication; and

(5) Treatment.

e. IA CFY program intervention shall be conducted as a component of the program for all women eligible and enrolled to receive IA CFY program services.

f. A health care provider who has a cooperative agreement with the IA CFY program shall be subject to the following:

(1) The health care provider agrees that reimbursement of procedures and services provided shall not exceed the amount that would be paid under Medicare Part B participating-provider rates as released annually at the beginning of each calendar year.

(2) A mammography health care provider shall ensure that the provider's facility has current FDA certification and ACR or state of Iowa accreditation and is a Medicare and Medicaid-approved facility utilizing BI-RADS and following ACR guidelines for mammography report content.

(3) A board-certified radiologist must be immediately available to determine selection of views and readings when a diagnostic mammogram is performed.

(4) The health care provider shall submit obtained cytology and pathology specimens to a CLIA-certified laboratory for processing. The laboratory shall provide cytological reading and analysis of cervical and vaginal Pap tests by certified/registered cytotechnologists. Cytology (Pap) tests shall be reported using current TBS terminology. The laboratory shall provide board-certified pathologists or experienced certified cytotechnologists to rescreen all analyses and readings of cervical and breast biopsies.

(5) The health care provider shall practice according to the current standards of medical care for breast and cervical cancer early detection, diagnosis, and treatment.

(6) Service delivery may be provided in a variety of settings. Service delivery must, however, include:

1. Providing screening services for specific geographic areas;
2. Providing a point of contact for scheduling appointments;
3. Providing age and income eligibility screening;
4. Providing breast and cervical cancer screening and heart disease and stroke screening to eligible women;
5. Providing referral and follow-up for women who have alert-value screening results;
6. Providing the required reporting system for screening and follow-up activities;
7. Providing population-based education, outreach, and recruitment activities;
8. Providing IA CFY program cardiovascular intervention as a component of the program for all women eligible for and enrolled to receive IA CFY program services; and
9. Submitting data within 60 days of service date to establish screening documentation.

(7) The health care provider shall ensure compliance with this chapter and other terms and conditions included in the cooperative agreement.

8.2(3) Referral, tracking, and follow-up utilizing a data system to monitor each enrolled woman's receipt of screening/rescreening, diagnostic, and treatment procedures shall be conducted by the IA CFY program and contracted county board of health designated agency staff.

a. The enrolled woman shall be notified by contracted county board of health designated agency staff of the results of the service, whether the results are normal, benign, or abnormal.

b. The data system shall provide tracking of appropriate and timely clinical services following an abnormal test result or diagnosis of cancer.

c. If the enrolled woman has an abnormal Pap test or breast screening or an alert-value heart disease risk factor, the health care provider shall provide to the woman a comprehensive referral directing her to appropriate additional diagnostic or treatment services.

d. The comprehensive referral shall be written. Follow-up shall be conducted to determine whether services were timely, completed, or met.

8.2(4) The IA CFY program and contracted county board of health designated agency staff shall provide case management and shall assist participants whose cancer was diagnosed through the program in obtaining needed treatment services.

8.2(5) IA CFY program staff shall use quality assurance and improvement techniques including use of established standards, systems, policies and procedures to monitor, assess and identify practical methods for improvement of the program and its components.

a. Quality assurance tools shall include utilizing FDA and ACR minimum standards for mammography facilities and CLIA minimum standards for cytopathology and pathology laboratories.

b. Quality assurance measures shall contribute to the identification of corrective actions to be taken to remedy problems found as a result of investigating quality of care.

8.2(6) Professional development shall be provided by the IA CFY program and contracted county board of health designated agency staff through a variety of channels and activities that enable professionals to perform their jobs competently, identify needs and resources, and contribute to ensuring that health care delivery systems provide positive clinical outcomes.

8.2(7) Using a variety of methods and strategies to reach priority populations, the IA CFY program and contracted county board of health designated agency staff shall provide population-based public education and recruitment that involve the systematic design and delivery of clear and consistent messages about breast and cervical cancer and the benefits of early detection. Outreach activities should focus on women who have never or rarely been screened and should work toward the removal of barriers to care (i.e., the need for child care, respite care, interpreter services and transportation) through collaborative activities with other community organizations.

8.2(8) The IA CFY program may develop coalitions and partnerships to bring together groups and individuals that establish a reciprocal agreement for sharing resources and responsibilities to achieve the common goal of reducing breast and cervical cancer mortality and heart disease and stroke mortality.

8.2(9) The IA CFY program shall conduct surveillance utilizing continuous, proactive, timely and systematic collection, analysis, interpretation and dissemination of breast and cervical cancer screening and heart disease and stroke risk factor behaviors and incidence, prevalence, survival, and mortality rates. Epidemiological studies shall be conducted utilizing MDEs and other data sources to establish trends of disease, diagnosis, treatment, and research needs. Program planning, implementation, and evaluation shall be based on the epidemiological evidence.

8.2(10) Evaluation of the program shall be conducted through systematic documentation of the operations and outcomes of the program, compared to a set of explicit or implicit standards or objectives.
[**ARC 0059C**, IAB 4/4/12, effective 5/9/12]

641—8.3(135) Participant eligibility criteria. An applicant for the IA CFY program must satisfy the criteria outlined in this rule. If an applicant does not meet these criteria, the applicant shall be provided information by contracted county board of health designated agency staff regarding IowaCare, free care, or sliding-fee clinics available in the area in which the applicant lives.

8.3(1) *Age.* An applicant for the IA CFY program must satisfy only one of these criteria.

a. Women 50 through 64 years of age, the program's priority population, shall receive annual breast and cervical (if appropriate) cancer screening.

b. Women 40 through 64 years of age shall receive cardiovascular risk factor screening in addition to breast and cervical cancer screening services.

c. Women 40 through 49 years of age shall receive annual breast and cervical (if appropriate) cancer screening.

d. Women under 40 years of age, if symptomatic for breast cancer, shall receive breast and cervical cancer screening services based upon funding availability.

e. Women 65 years of age and older shall be eligible to receive annual breast and cervical (if appropriate) cancer screening if they do not have Medicare Part B coverage.

8.3(2) *Income.*

a. IA CFY program income guidelines are based upon 250 percent of the federal poverty level, which is set annually by CMS. New IA CFY program income guidelines will be adjusted following any change in CMS guidelines.

b. Self-declaration of income may be accepted.

c. Eligibility shall be based on net income for the household.

d. Assets shall not affect income status and shall not be counted when eligibility under the IA CFY program is determined.

8.3(3) *Insurance.*

a. The IA CFY program shall determine a woman to be uninsured if the woman does not have health insurance coverage.

b. The IA CFY program shall determine a woman to be underinsured if the woman has health insurance with unreasonably high copayments, deductibles, or coinsurance or the insurance does not cover IA CFY program-covered services.

c. Women who have Medicaid or Medicare Part B are not eligible. EXCEPTIONS: IowaCare, Medicaid with spenddown, Iowa family planning network.

8.3(4) *Residency.*

a. A woman must be a resident of Iowa or of a state that shall enroll a woman in the BCCT option of Medicaid if the woman is screened or diagnosed by the IA CFY program.

b. A woman who is a resident of a state that does not accept women into the BCCT option of Medicaid and who chooses to continue to receive services in the IA CFY program must be informed that she may not be able to have her treatment paid for by the BCCT option of Medicaid if she does not receive services in her state of residence.

c. Proof and length of residency in Iowa are not required.

8.3(5) *Ineligible.* The IA CFY program does not provide coverage for:

a. Men.

b. Women with Medicare Part B coverage.

c. Women 39 years of age and younger unless they have symptoms of breast cancer.

[**ARC 0059C**, IAB 4/4/12, effective 5/9/12]

641—8.4(135) Participant application procedures for IA CFY program services.

8.4(1) *Enrollment.* After a woman is determined eligible for services:

a. The woman must complete, sign, and return a consent and release form to the IA CFY program. The date on the signed form shall be the participant's enrollment date.

b. Upon enrollment, the participant must select an IA CFY program health care provider and is eligible for services for 12 months from the enrollment date, subject to restrictions in program coverage as provided in rule 641—8.5(135).

c. If a participant is unable to access a particular health care provider due to unavailability of appointments or if a participant requests to change to another health care provider, designated agency staff shall assist the participant in choosing another IA CFY program health care provider who is available in the participant's area.

8.4(2) *Reenrollment.*

a. A participant's continued eligibility for program coverage shall be determined annually.

b. No more than 45 days prior to the end of the 12-month coverage period, the IA CFY program shall contact the participant to see if she wishes to reenroll in the program.

c. If a participant wishes to reenroll, she must complete, sign and return a consent and release form before receiving any further services.

8.4(3) *Termination of enrollment.* The IA CFY program shall terminate a participant's enrollment if the participant:

a. Requests termination from the program;

b. No longer meets the criteria set forth in rule 641—8.3(135);

c. Does not return a signed IA CFY program consent and release form; or

d. Refuses to receive screening and diagnostic services through an IA CFY program health care provider.

[**ARC 0059C**, IAB 4/4/12, effective 5/9/12]

641—8.5(135) Priority for program expenditures.

8.5(1) In the event the IA CFY program director determines that there are inadequate funds to meet participants' needs, either attributable to a reduction in federal funding from the CDC or to a projected enrollment of women in excess of anticipated enrollment, the program director may restrict new applicants' participation in the IA CFY program as follows:

a. First priority shall be given to women 50 through 64 years of age.

b. Second priority shall be given to women 40 through 49 years of age who are symptomatic.

c. Third priority shall be given to women 40 through 49 years of age who are asymptomatic.

d. Fourth priority shall be given to women 65 years of age and older who do not have Medicare Part B coverage.

8.5(2) In the event that the financial demand abates, the program director shall withdraw the financial shortfall determination, at which time women shall be eligible for program services in accordance with rule 641—8.3(135).

[**ARC 0059C**, IAB 4/4/12, effective 5/9/12]

641—8.6(135) Right to appeal. If an individual disagrees with or is dissatisfied with program eligibility, the covered-service determination, or the decision of the program, the individual has the right to appeal the decision or action.

8.6(1) The appeal shall be in writing and shall be submitted, within ten working days of the decision or action, to the designated agency personnel with whom the individual has been working.

8.6(2) The designated agency staff shall contact a state IA CFY program staff person and shall provide the information regarding the appeal to the staff person.

8.6(3) State IA CFY program staff shall confer with the bureau chief supervising the IA CFY program and provide a decision to the designated agency staff within five business days. A decision made by state IA CFY program staff shall be delivered by telephone, if possible, to the individual making the appeal and shall be followed by a written notification of the decision. The decision of state IA CFY program staff shall be considered a final agency decision in accordance with Iowa Code chapter 17A.

[**ARC 0059C**, IAB 4/4/12, effective 5/9/12]

641—8.7(135) Verification for the breast or cervical cancer treatment (BCCT) option of Medicaid. The Iowa department of public health and the department of human services have coordinated to develop procedures for women to access Medicaid coverage for treatment of breast or cervical cancer.

8.7(1) Before referring a woman to her county of residence's local office of the department of human services, a contracted county board of health designated agency staff member shall document the following regarding the woman:

a. The woman is currently enrolled in the IA CFY program. To be considered enrolled in the program, the woman must meet program age guidelines, have at least one of the basic screening services (Pap test, screening mammogram, or CBE) or diagnostic procedures paid for by the IA CFY program or with Susan G. Komen for the Cure funds, and be in need of treatment for breast or cervical cancer or precancerous conditions; or

b. The woman was enrolled in NBCCEDP and has moved to Iowa. To be considered enrolled in NBCCEDP, the woman must meet the Iowa program age guidelines, have at least one of the basic screening services (Pap test, screening mammogram, or CBE) or a diagnostic procedure paid for by the NBCCEDP or with Susan G. Komen for the Cure funds, and be in need of treatment for breast or cervical cancer or precancerous conditions; and

c. The woman has creditable coverage circumstances or has no creditable coverage for breast or cervical cancer treatment.

8.7(2) The BCCT option of Medicaid is administered by the Iowa department of human services under 441 Iowa Administrative Code Chapter 75, "Conditions of Eligibility."

[**ARC 0059C**, IAB 4/4/12, effective 5/9/12]

These rules are intended to implement Iowa Code sections 135.11(1) and 135.39 and 42 U.S.C. Section 300k, as amended.

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CHAPTER 10
IOWA GET SCREENED: COLORECTAL CANCER PROGRAM

641—10.1(135) Purpose. The Iowa get screened (IGS): colorectal cancer program was established in 2009 through a cooperative agreement with the Centers for Disease Control and Prevention and is administered by the department. The goal of the IGS program is to reduce the incidence, mortality and prevalence of colorectal cancer in Iowa by increasing the number of men and women who receive colorectal cancer screenings. Through the program, fecal immunochemical tests (FITs) and colonoscopies will be provided to eligible Iowans. Along with providing screenings, the program also facilitates supportive services and referral for diagnosis and treatment to Iowans with abnormal screening results. Iowans who are eligible to enter the program must be 50 to 64 years of age, be underinsured or uninsured, have incomes of up to 250 percent of the federal poverty level (FPL) and have an average or increased risk for developing colorectal cancer.
[**ARC 0060C**, IAB 4/4/12, effective 5/9/12]

641—10.2(135) Definitions. For purposes of this chapter, the following definitions apply:

"Advanced registered nurse practitioner" means an individual licensed to practice under 655—Chapter 7.

"Case management" means establishing, brokering and sustaining a system of available clinical and essential support services for all individuals enrolled in the program.

"Colon" means large intestine or large bowel.

"Colonoscope" means a thin, flexible tube that takes pictures of the colon and rectum during a colonoscopy.

"Colonoscopist" means a licensed provider who administers a colonoscopy.

"Colonoscopy" means a visual examination of the inner surface of the colon by means of a colonoscope.

"Colorectal cancer," "colon cancer" or *"CRC"* means cancer that starts in the colon or the rectum.

"Colorectal cancer data elements" or *"CCDE"* means a set of standardized data elements developed by the Centers for Disease Control and Prevention, Division of Cancer Prevention and Control, to ensure that consistent and complete information is collected on participants whose screening or diagnosis was paid for through the IGS program with federal funding.

"Department" means the Iowa department of public health.

"Double-contrast barium enema" means an X-ray examination of the entire large intestine (colon) and rectum in which barium and air are introduced gradually into the colon by a rectal tube.

"Eligibility criteria" means a set of questions that a potential participant is asked to ensure the participant meets program qualifying standards including targeted age, income guidelines, level of risk for colorectal cancer and screening determination guidelines. Qualifying standards are outlined in the CDC's Colorectal Control Cancer Program Policies and Procedures and are based on recommendations from the United States Preventive Services Task Force (USPSTF).

"Endoscopist" means a physician who is licensed to perform a visual inspection of any cavity of the body by means of an endoscope.

"Familial adenomatous polyposis" or *"FAP"* means an inherited colorectal cancer syndrome and accounts for 1 percent of all cases of colorectal cancer. "Familial" means FAP runs in families; "adenomatous" means the type of polyps detected in the colon and small intestine that may become cancerous; and "polyposis" means the condition of having multiple colon polyps. The gene for FAP is on the long arm of chromosome 5 and is called the APC gene.

"Family history" means that a person's close relatives (parents, siblings or children) have had colorectal cancer and, therefore, the person is somewhat more likely to develop that type of cancer, especially if the family member developed the cancer at a young age. If many family members have had colorectal cancer, the chances that the person will develop colorectal cancer increase even more.

"Fecal immunochemical test" or *"FIT"* means the primary screening method for the IGS program to test for hemoglobin in the feces, a possible sign of colorectal cancer.

"Federally qualified health center" or *"FQHC,"* referred to in Iowa as a community health center or "CHC," means a federally funded nonprofit health center or clinic that serves medically underserved areas and populations. Federally qualified health centers provide primary care services regardless of ability to pay. Services shall be provided on a sliding fee scale based on ability to pay. The IGS program utilizes community health centers to provide services to target populations.

"Final diagnosis" means the process of identifying or determining the nature and cause of a disease or injury through evaluation of patient history, examination and review of laboratory data.

"Health care provider" means any physician, advanced registered nurse practitioner, or physician assistant who is licensed by the state of Iowa and provides care to IGS-enrolled participants.

"Hereditary nonpolyposis colorectal cancer" or *"HNPCC"* means an inherited colorectal cancer syndrome and accounts for 5 percent of all cases of colorectal cancer. "Hereditary" means HNPCC is inherited or can be passed from parent to child; "nonpolyposis" contrasts HNPCC to the inherited condition FAP where hundreds to thousands of polyps develop in the colon; "colorectal cancer" is the most frequent cancer that develops in these families. Patients with HNPCC have an 80 percent chance of developing colorectal cancer.

"Informed consent" means the participant has signed the IGS informed consent and release of medical information form and therefore voluntarily agrees to participate and receive colorectal services and appropriate follow-up through the IGS program. Consent for services can be canceled at any time by the participant.

"In-reach" means the method that will be used in the local program to recruit participants. In-reach targets existing clients through the Iowa care for yourself program and federally qualified health centers.

"Iowa care for yourself program" or *"IA CFY program"* means a program that provides breast and cervical cancer screening, diagnostics and cardiovascular-related intervention services to low-income, underinsured or uninsured women 40 to 64 years of age. The IA CFY program integrates program services, as possible, with the IGS program. Some IA CFY program participants have been enrolled through in-reach activities into the IGS program.

"Iowa get screened: colorectal cancer program" or *"IGS program"* means the state program funded through the federal Colorectal Cancer Control Program (CRCCP). This program requires policy and systems change, public education and awareness and limited screening activities. The IGS program has been made possible in Iowa through a cooperative agreement awarded to the department through the competitive bid grants procurement process by the United States Department of Health and Human Services, Division of the Centers for Disease Control and Prevention.

"Large intestine" means the last part of the digestive tract. The large intestine is divided into sections including the ascending which begins at the cecum on the right side, the transverse which is the horizontal section, and the descending which is on the left side and includes the sigmoid and the rectum. The primary function of the large intestine is the absorption of water and the formation and collection of feces.

"Local program" means the entity or facility in which IGS services are being offered through a contractual agreement with the department.

"Local program coordinator" means the individual within a local program who is providing services to a participant.

"Medical advisory board" or *"MAB"* means the body that provides oversight of the quality of screening services delivered through the IGS program.

"Oncologist" means a specialist physician who treats or studies the physical, chemical and biologic properties and features of a neoplasm, including causation, pathogenesis and treatment.

"Participant" means an individual enrolled in the IGS program to receive colorectal cancer screening services in accordance with the United States Preventive Services Task Force (USPSTF) recommendations.

"Pathologist" means a specialist physician who identifies diseases by studying cells and tissues under a microscope.

"Patient navigator" means the individual who identifies and coordinates resources for a participant with a screening diagnosis of colorectal cancer who may require physical, emotional, financial or other

support through the cancer journey. Navigation services are provided through a cooperative agreement with the American Cancer Society.

"Physician" means an individual licensed to practice under Iowa Code chapter 148.

"Physician assistant" means an individual licensed to practice under Iowa Code chapter 148C.

"Polyp" means a growth from a mucous membrane commonly found in organs such as the rectum, the uterus and the nose. Certain types of polyps, such as adenomas, may develop into cancer.

"Precancerous" means a condition that may become or is likely to become cancer.

"Primary care provider" means a health care provider who provides definitive care to a patient at the point of first contact and takes continuing responsibility for providing the patient's care.

"Provider agreement" means a signed cooperative agreement between the department and another party, for example, a health care provider.

"Radiologist" means a specialist physician trained in creating and interpreting pictures of areas inside the body. The pictures are produced with X-rays, sound waves or other types of energy.

"Rectum" means the last part of the large intestine where stool is stored prior to evacuation through the anus (external opening of the digestive system).

"Referral" means directing program participants with abnormal screening results to appropriate resources for follow-up action.

"Screening" means the search for disease, such as cancer or precancerous polyps in people without symptoms.

"Secondary complication" means an additional problem that arises following a procedure, treatment or illness.

"Surveillance" means a periodic colonoscopy as recommended by a physician on a case-by-case basis for participants with a prior history of adenoma(s) or colorectal cancer in accordance with USPSTF recommendations. The purpose of surveillance is to rescreen and remove polyps that were missed on the initial colonoscopy or that developed in the interval since the previous colonoscopy.

"Underinsured" means an individual with income at 250 percent of the federal poverty guideline or lower with health insurance that has unreasonably high copayments, deductibles or coinsurance.

"United States Preventive Services Task Force" or *"USPSTF"* means an independent panel of nonfederal health care experts that evaluates the latest scientific evidence on clinical preventive services and then sets recommendations for preventive services including colorectal cancer screening. These recommendations by USPSTF are the guidelines that are followed for recommended colorectal cancer screening by the IGS program.

[**ARC 0060C**, IAB 4/4/12, effective 5/9/12]

641—10.3(135) Components of the Iowa get screened (IGS): colorectal cancer program. The program shall include the following key components:

10.3(1) Program and fiscal management shall be conducted by ensuring strategic planning, implementation, coordination, integration and evaluation of all programmatic activities and administrative systems, as well as the development of key communication channels and oversight mechanisms to aid in these processes. Program management shall ensure that infrastructure adequately supports service delivery.

10.3(2) Service delivery to screen for colorectal cancer for participants enrolled in the IGS program shall be provided by local program coordinators and enrolled heath care providers through contractual arrangements.

a. The IGS program provides reimbursement for the following screening tests, procedures, preparations and tissue analyses when those services are provided by a participating health care provider who has a provider agreement with the IGS program. Payment is based on Medicare Part B participating provider rates (Title XIX).

(1) Fecal immunochemical tests annually;

(2) Colonoscopy every 10 years from initial screen or as prescribed by a physician for surveillance in accordance with USPSTF recommendations;

(3) Biopsy/polypectomy during a colonoscopy;

(4) Bowel preparation;

(5) Moderate sedation for colonoscopy;

(6) One office visit related to IGS program-covered colorectal cancer tests;

(7) One office visit related to colorectal cancer follow-up diagnostic test results;

(8) Total colon examination with either colonoscopy (preferred) or double contrast barium enema if medically prescribed by doctor;

(9) Pathology services.

b. The IGS program does not provide reimbursement for the following:

(1) Screening tests requested at intervals sooner than recommended by the USPSTF;

(2) CT colonography (or virtual colonoscopy) as a primary screening test;

(3) Computed tomography scans (CT or CAT scans) requested for staging or other purposes;

(4) Surgery or surgical staging, unless specifically required and approved by the IGS program's MAB to provide a histological diagnosis of cancer;

(5) Any treatment related to the diagnosis of colorectal cancer;

(6) Any care or services for complications that result from screening or diagnostic tests provided by the IGS program;

(7) Medical evaluation of symptoms that make individuals at high risk for CRC;

(8) Diagnostic services for participants who had an initial positive screening test performed outside of the program;

(9) Management and testing (e.g., surveillance colonoscopies and medical therapy) for medical conditions, including inflammatory bowel disease, ulcerative colitis or Crohn's disease;

(10) Genetic testing for participants who present with a history suggestive of a hereditary nonpolyposis colorectal cancer (HNPCC) or familial adenomatous polyposis (FAP);

(11) Use of propofol as anesthesia during endoscopy, unless specifically required and approved by the IGS program's MAB in cases where the participant cannot be sedated with standard moderate sedation; and

(12) Treatment for colorectal cancer.

c. A local program that has a signed contract with the IGS program shall be responsible for the following:

(1) Recruitment of participants;

(2) Eligibility determination;

(3) Enrollment;

(4) Patient support services;

(5) Tracking of follow-up care;

(6) Documentation and data reporting; and

(7) Recall of participants who remain eligible for continued services.

d. Local program coordinators must use a case management services approach throughout the screening process to ensure that all participants:

(1) Receive program information and colorectal cancer educational materials;

(2) Are assisted, according to each participant's need, to reduce barriers to screening including, for example, fears, cultural beliefs, language, transportation, understanding of information, and insurance enrollment;

(3) Receive guidance throughout the screening, diagnostic and treatment processes;

(4) Understand colorectal cancer screening procedures and health care provider recommendations;

(5) Receive appropriate services according to diagnosis including follow-up; and

(6) Have the opportunity to get questions answered throughout the process.

e. A health care provider that has a provider agreement with the department shall be subject to the following provisions:

(1) The health care provider agrees that reimbursement of procedures and services provided shall not exceed the amount that would be paid under Medicare Part B participating provider rates of Title XVIII of the Social Security Act.

(2) The health care provider shall provide the participant and local program coordinator timely colorectal cancer screening results and follow-up recommendations.

(3) The gastrointestinal health care provider shall submit pathology specimens to a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory for processing.

(4) The health care provider shall practice according to the current standards of medical care for colorectal cancer early detection, diagnosis and treatment.

(5) The health care provider or entity shall submit universal claim forms, originals of the HCFA 1500 or the UB 92, for reimbursement of IGS program-covered services in accordance with the provider agreement.

(6) The health care provider may deliver services in a variety of settings. Service delivery shall include:

1. Working with local coordinators as they refer IGS program participants to provide follow-up or initial colorectal cancer screening services;

2. Providing a point of contact for program communication with the department to relay information that may include updating data, follow-up information and final diagnosis;

3. Providing screening services for a specific geographic area; and

4. Providing referral and follow-up for participants with abnormal screening results.

(7) The health care provider shall ensure compliance with this chapter and other terms and conditions included in the provider agreement or contract.

10.3(3) IGS program and contracted local program staff shall conduct referral, tracking and follow-up utilizing a Web-based data system to monitor each enrolled participant's receipt of screening, rescreening and diagnostic procedures.

a. The enrolled participant shall be notified within 30 days of the screening service by contracted local program staff or the enrolled health care provider of the results of the service, whether the results are normal, benign or abnormal.

b. The contracted local program shall use the IGS program data system to enter appropriate and timely clinical services, including screening and diagnostic test results, follow-up, and completion of screening services.

c. If the enrolled participant has an abnormal colorectal cancer screening test, the health care provider or local coordinator shall provide to the participant a comprehensive referral directing the participant to appropriate additional diagnostic or treatment services. When the results of a FIT screen are positive, the local coordinator shall work with the participant and enrolled health care provider to schedule a colonoscopy.

d. The local program coordinator shall follow up with the provider to obtain results if not provided in a timely manner.

e. IGS program staff shall follow up with the local program coordinator if results have not been entered in the IGS data system in a timely manner.

10.3(4) If treatment services are needed, the participant's health care provider may perform a consultation in order to educate the participant about treatment options. If more than two office visits are warranted for a participant throughout the screening cycle, subsequent office visits must be authorized by IGS program staff.

10.3(5) IGS program staff shall use quality assurance and process improvement techniques including use of established standards, systems, policies and procedures to monitor, assess and identify practical methods for improvement of the IGS program and its components. Quality assurance and process improvement are integral components of the IGS program and contribute to program success. As part of the vision, to reduce morbidity and mortality from colorectal cancer, high-quality, timely participant services are essential. IGS program requirements and monitoring activities shall include:

a. Professional licensure and accreditation. Health facilities and health care providers must be currently licensed or accredited to practice in the state of Iowa.

b. Reporting standards. Radiological, laboratory and pathology and other results must be reported according to national standards.

c. Standards for adequacy of follow-up. Data reports shall track appropriate and timely short-term, diagnostic and rescreening services.

d. A case management services approach. Local program staff shall follow the participants through the colorectal cancer screening process from the first contact to final diagnosis and as needed for referral to treatment and patient navigation services. Local program staff shall be responsible for documenting these activities as described in paragraph 10.3(2)*"d."*

e. Accurate data collection and documentation.

(1) Colorectal cancer data elements (CCDEs) are reported to CDC semiannually by the department.

(2) Site visits are conducted at local program sites to provide technical assistance, give feedback on program performance, evaluate case management process and if needed conduct a walk-through of current services to provide feedback.

f. Evaluation. Workplans shall be reviewed and surveys conducted in the community and with program partners. Reports on progress and face-to-face meetings shall be conducted routinely and on an as-needed basis to assess how the IGS program is meeting CDC program objectives.

g. Process improvement and systems change activities.

h. Adherence to CDC policies and guidelines.

i. Approval and utilization of additions to the local program allowable procedures list.

10.3(6) Professional development shall be provided by the IGS program and contracted local program staff through a variety of channels including educational activities that enable professionals to perform their jobs competently, to identify needs and resources, and to ensure that health care delivery systems provide appropriate clinical outcomes for colorectal cancer screening services.

10.3(7) The IGS program and contracted local program staff shall provide in-reach education and recruitment that involve the systematic design and delivery of clear and consistent messages about colorectal cancer (CRC) and the benefits of early detection using a variety of methods and strategies. In-reach activities shall focus on men and women who have never or rarely been screened for CRC and shall work toward the removal of barriers to care (e.g., by providing respite care, interpreter services and transportation) through collaborative activities with other community organizations. In-reach shall be targeted toward the participants already being served through the IA CFY program and patients at FQHCs. Public education and outreach activities for community awareness of CRC are supported and mandatory for the project.

10.3(8) The IGS program may develop coalitions and partnerships to establish a common agreement for sharing resources and responsibilities to achieve the common goal of reducing colorectal cancer mortality.

10.3(9) The IGS program shall conduct surveillance utilizing continuous, proactive, timely and systematic collection, analysis, interpretation and dissemination of colorectal cancer screening prevalence, survival and mortality rates. Studies shall be conducted utilizing minimum data elements and other data sources to establish trends of disease, diagnosis, treatment, and research needs. IGS program planning, implementation and evaluation shall be based on the data.

10.3(10) Evaluation by the IGS program evaluator shall be conducted through documentation of services, operation processes at the state and local program levels and outcomes of the IGS program. The evaluation shall include face-to-face interviews with state and local IGS program staff involved in IGS program delivery. IGS program evaluation shall include suggestions to help IGS and local program staff meet the recommendations as set in the CRCCP program manual. Recommendations shall then be incorporated into the program workplan by the state staff.

[**ARC 0060C**, IAB 4/4/12, effective 5/9/12]

641—10.4(135) Medical advisory board. The medical advisory board or MAB is made up of a diverse group of professionals (e.g., primary care providers, nurses, endoscopists, oncologists, pathologists, radiologists, coordinators, patient navigators and the IGS program evaluator) who offer their expertise on issues including enrollment, screening, diagnosis and treatment.

10.4(1) The MAB provides oversight of the quality of screening services delivered. MAB members may participate in other IGS program activities including colorectal cancer awareness month activities and education projects.

10.4(2) The primary role of the MAB is to:

a. Assist in the establishment of IGS program eligibility and service delivery criteria (e.g., defining underinsured, establishing guidelines for diagnostic testing, surveillance intervals, etc.);

b. Monitor quality of screening, rescreening, diagnostic and surveillance services;

c. Assist with identification of resources for treatment and referral of individuals who are ineligible for the program;

d. Provide direction on IGS program policy development and data collection; and

e. Approve additions to the IGS program allowable procedures list, as needed.

[**ARC 0060C**, IAB 4/4/12, effective 5/9/12]

641—10.5(135) Participant eligibility criteria. An applicant for the IGS program must satisfy the criteria outlined in this rule. If an applicant does not meet these criteria, the applicant shall be provided information by contracted local program staff regarding IowaCare, free care or sliding-fee clinics available in the area in which the applicant lives.

10.5(1) *Age.* Individuals 50 through 64 years of age shall be the target population to receive colorectal cancer screening.

10.5(2) *Income.*

a. The IGS program income guidelines are based upon 250 percent of the federal poverty level (FPL), which is set annually by the Centers for Medicare and Medicaid Services (CMS). New IGS program income guidelines will be adjusted following any change in CMS guidelines.

b. Self-declaration of income may be accepted.

c. Eligibility shall be based on net income for the household.

d. Assets shall not affect income status and shall not be counted when eligibility under the IGS program is determined.

10.5(3) *Insurance.*

a. The IGS program shall determine individuals to be uninsured if they do not have health insurance coverage.

b. The IGS program shall determine individuals to be underinsured if they have health insurance with unreasonably high copayments, deductibles or coinsurance or the insurance does not cover the IGS program's covered services.

c. Individuals who have Medicaid or Medicare Part B are not eligible. Individuals who have IowaCare, Medicaid with spend down, or Iowa family planning network may be eligible.

10.5(4) *Residency.*

a. Individuals must reside in the state of Iowa.

b. Individuals shall have an established address and contact information as needed for program staff to provide screening results, rescreens, and follow-up services.

10.5(5) *Risk level.* Individuals with an average or increased risk for developing colorectal cancer as defined by the recommendations of the USPSTF may qualify for IGS program services.

10.5(6) *Ineligible.* The IGS program does not provide coverage for:

a. Individuals with Medicare Part B coverage.

b. Individuals 49 years of age and younger.

c. Individuals 65 years of age and older.

d. Individuals who do not have a primary care provider.

e. Individuals at high risk for developing colorectal cancer. Individuals at high risk include:

(1) A genetic diagnosis of familial adenomatous polyposis (FAP) or hereditary nonpolyposis colorectal cancer (HNPCC),

(2) A clinical diagnosis or suspicion of FAP or HNPCC, or

(3) A history of inflammatory bowel disease (ulcerative colitis or Crohn's disease).

f. Individuals experiencing the following gastrointestinal symptoms:

(1) Rectal bleeding, bloody diarrhea, or very dark blood in the stool within the past six months;
(2) Prolonged change in bowel habits;
(3) Persistent/ongoing abdominal pain;
(4) Recurring symptoms of bowel obstruction; or
(5) Significant unintentional weight loss.

[**ARC 0060C**, IAB 4/4/12, effective 5/9/12]

641—10.6(135) Participant application procedures for IGS program services.

10.6(1) *Enrollment.* After an individual is determined eligible for services and agrees to participate in the IGS program, the following provisions shall apply:

a. A prospective participant must complete the Informed Consent and Release of Medical Information form and submit it to the local program coordinator in order to become enrolled in the program and be considered a program participant. The date on the signed form shall be the participant's enrollment date.

b. Upon enrollment, the participant shall be eligible for services for 12 months beginning from the date of enrollment, subject to restrictions in funding and program coverage as provided in subrules 10.6(2), 10.6(3) and 10.7(1).

10.6(2) *Reenrollment.*

a. A participant's continued eligibility for IGS program coverage shall be determined annually.

b. The IGS local program coordinator shall reenroll the participant in the program no more than 30 days prior to the end of the 12-month coverage period in accordance with USPSTF guidelines or a physician's recommendation.

c. When a participant reenrolls, the participant must complete, sign and return the consent and release form to the local program coordinator before receiving any further services.

10.6(3) *Termination of enrollment.* The IGS program shall terminate a participant's enrollment if the participant:

a. Requests termination from the program;

b. No longer meets the criteria set forth in rule 641—10.5(135);

c. Does not return a signed IGS program consent and release form; or

d. Refuses to receive screening and diagnostic services through an IGS program health care provider.

[**ARC 0060C**, IAB 4/4/12, effective 5/9/12]

641—10.7(135) Priority for program expenditures.

10.7(1) In the event the IGS program director certifies that there are inadequate funds to meet participants' needs, either attributable to a reduction in federal funding from the CDC or to a projected enrollment of participants in excess of anticipated enrollment, the program director may restrict new applicants' participation in the IGS program. First priority shall be given to individuals who have never been screened for CRC.

10.7(2) In the event that the financial demand abates, the program director shall withdraw the financial shortfall certification, at which time the individual shall be eligible for program services in accordance with rule 641—10.5(135).

[**ARC 0060C**, IAB 4/4/12, effective 5/9/12]

641—10.8(135) Right to appeal. If an individual disagrees with or is dissatisfied with IGS program eligibility, the covered-service determination or the decision of the IGS program, the individual has the right to appeal the decision or action.

10.8(1) The appeal shall be in writing and shall be submitted within ten working days of the decision or action to the local program staff with whom the individual has been working.

10.8(2) The local program staff shall contact an IGS program staff person with the information regarding the appeal within three business days.

10.8(3) IGS program staff shall confer with the bureau chief for the IGS program at the department and provide a decision to the local program staff within five business days. A decision made by IGS

program staff shall be delivered by telephone, if possible, to the individual making the appeal and shall be followed by a written notification of the decision. The decision of IGS program staff shall be considered a final agency decision in accordance with Iowa Code chapter 17A.
[**ARC 0060C**, IAB 4/4/12, effective 5/9/12]

641—10.9(135) Colorectal cancer treatment. The IGS program does not pay for colorectal cancer treatment services. A participant will be assisted with enrolling in the IowaCare program, in the event treatment services are needed. If a participant needs treatment, the local program coordinator will refer the participant to an American Cancer Society patient navigator to identify and coordinate resources for the participant who may require physical, emotional, financial or other support through the cancer journey. The patient navigator and IGS program staff will work together to assist a participant needing treatment. It is an expectation of the cooperative agreement that a participant gets help obtaining treatment services free or at an affordable cost based on the participant's annual income and ability to pay for the services.
[**ARC 0060C**, IAB 4/4/12, effective 5/9/12]

These rules are intended to implement Iowa Code sections 135.11(1) and 135.39 and 42 U.S.C. Section 241(a), as amended.

[Filed ARC 0060C (Notice ARC 9997B, IAB 2/8/12), IAB 4/4/12, effective 5/9/12]

CHAPTER 37
BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM

Rescinded IAB 4/4/12, effective 5/9/12; see 641—Chapter 8

CHAPTER 85
LOCAL SUBSTITUTE MEDICAL DECISION-MAKING BOARDS

641—85.1(135) Purpose. The purpose of this chapter is to establish the requirements and procedures for local substitute medical decision-making boards. Counties may establish local substitute medical decision-making boards for patients who are incapable of making their own medical care decisions and who have no other surrogate decision maker available. If the patient has designated an individual to have durable power of attorney for health care or has a guardian or has family members who are reasonably available, willing and able to make medical care decisions, the case should not be submitted to the substitute medical decision-making board. If the patient has provided advance directives which cover the proposed care, the case should not be submitted to the board.

641—85.2(135) Definitions. For the purpose of these rules, the following definitions shall apply:

85.2(1) *"Conflict of interest"* means a standard which precludes the participation of a panel member in the proceedings with regard to a patient whenever the panel member is a relative of the patient, is a direct care provider of the patient or has a financial interest in the patient.

85.2(2) *"Correspondent"* means a person other than a relative of the patient who has demonstrated a genuine interest in promoting the best interest of a patient by having a personal relationship with the patient, by participating in the planning of a patient's care and treatment, by regularly visiting the patient, or by regularly communicating with the patient.

85.2(3) *"Department"* means Iowa department of public health.

85.2(4) *"Local board"* means a local substitute medical decision-making board established under Iowa Code section 135.29.

85.2(5) *"Medical care"* means care a reasonably prudent person would consider to be medically necessary. It includes, but is not limited to, procedures which involve any significant invasion of bodily integrity requiring an incision or producing substantial pain, discomfort, debilitation or which has a potential for significant bodily harm. This includes, but is not limited to, any medical, surgical or diagnostic intervention or procedure for which a general anesthetic is used. Medical care may include placement decisions where there is inadequate time to obtain appointment of a guardian and the placement is a medical consideration or a medical necessity.

The definition does not include discontinuance of medical treatment which is sustaining life functions because the board does not have authority to make this decision.

The definition also does not include the following types of care which can ordinarily be provided without special approval and do not need to be submitted to the board for consideration:

a. Routine office-based care or routine dental care;

b. Routine diagnosis or treatment such as extraction of bodily fluids for analysis, administration of medications or routine activities of daily living support;

c. Any procedure which is provided under emergency circumstances.

85.2(6) *"Other surrogate decision maker"* means an attorney-in-fact, guardian, spouse, adult child, parent or an adult sibling who is reasonably available, willing and able to make a medical care decision.

85.2(7) *"Panel"* means a group of three or more members of a local board who are appointed by the chairperson of that board to hear a case when an application has been filed with the board.

85.2(8) *"Patient"* means the person for whom the medical care decision is proposed. They may be in a hospital, long-term care facility, home, or other setting.

85.2(9) *"Person incapable of making their own medical care decisions"* means a patient who is unable to adequately understand and appreciate the nature and consequences of a proposed medical care decision, including the benefits and risks of the proposed medical care and of alternatives to such care, and cannot thereby reach an informed decision to consent or refuse such care in a knowing and voluntary manner that promotes the patient's well-being and autonomy. This incapability may be temporary or permanent.

85.2(10) *"Physician"* means any individual licensed under Iowa Code chapter 148.

85.2(11) Rescinded IAB 4/4/12, effective 5/9/12.
[**ARC 0061C**, IAB 4/4/12, effective 5/9/12]

641—85.3(135) Appointment of local boards.

85.3(1) The county board of supervisors may establish and fund a local substitute medical decision-making board. The board shall include one or more representatives from each of the following three categories:

a. Physicians, nurses, or psychologists licensed by the state of Iowa.

b. Attorneys admitted to the practice of law in Iowa or social workers.

c. Other individuals with recognized expertise or interest in persons unable to make their own medical care decisions not included in *"a"* and *"b"* above.

The county board of supervisors may appoint and fund a hospital ethics committee to serve as the local decision-making board provided that the composition of the committee fulfills the above requirements.

85.3(2) County boards of supervisors may join together to form a multicounty local substitute medical decision-making board pursuant to Iowa Code chapter 28E. If a multicounty board is established, the agreement shall specify the procedure for appointment of board members and the procedure for allocation of expenses.

85.3(3) Board members shall be appointed to terms of three years with staggered terms.

85.3(4) The board shall elect a chairperson at the first meeting of each fiscal year.

85.3(5) The county board of supervisors shall notify the department when a local board is appointed and shall submit a list of the members appointed.
[**ARC 0061C**, IAB 4/4/12, effective 5/9/12]

641—85.4(135) Filing an application.

85.4(1) Any person having knowledge and concern may file the application on behalf of any patient residing within the geographic area served by the local board, when the person filing the application believes the patient is incapable of decision making, is in need of medical care, and has no other surrogate decision maker available.

85.4(2) The local board of the county of residence of the patient shall have jurisdiction except the local board may, by mutual consent, transfer jurisdiction to the local board in the county where the treatment is being considered.

85.4(3) The application shall be made in writing and shall include the following:

a. The relationship of the person filing the application to the patient.

b. A statement that the patient does not have an attorney-in-fact, guardian, spouse, adult child, parent or an adult sibling who is reasonably available, willing and able to make the medical care decision. The application shall provide the factual basis for such a statement, including the efforts made to contact such persons.

c. The reasons for believing that the person lacks the capability to consent to or refuse medical care and the factual basis supported by an appropriate statement for this belief.

d. The patient's opinion regarding the proposed care, if known, and the source(s) of the information regarding this opinion.

e. If the patient's opinion regarding the proposed care is not known, the person filing the application shall include a stated opinion on whether the best interests of the patient would be promoted by such care and the basis for the opinion.

f. Any other information that may be necessary to determine the need for such care, including a copy of a second medical or dental opinion which would be required by a prudent physician or dentist based on the nature of the proposed medical care.

g. A statement, completed, signed and dated by a physician or dentist including:

(1) A description of the proposed medical care and the patient's medical or dental condition which requires such treatment indicating the date of diagnosis;

(2) The risks and benefits to the patient of the proposed care and any alternative treatments including consideration and consequences of nontreatment; and

(3) A statement whether the patient has any medical or dental condition which would prevent the patient's travel to or presence at the panel meeting and including a description of such condition.

h. The application shall be signed and dated by the person filing it stating that the information on the application is true to the best of that person's knowledge, except for any portion signed and dated by another person who shall make a similar statement as to that portion.

641—85.5(135) Notification of patient and review of application.

85.5(1) When an application is received, the patient shall be notified that an application has been submitted, a hearing will be scheduled, and the patient will be notified of the time and place of the hearing. The notification shall inform the patient of the right to be present, to testify orally or in writing, and to designate someone to represent the patient at the hearing. The hearing shall be held no less than 48 hours after the patient receives this notification.

85.5(2) The board chairperson or designee shall preliminarily review the application to ascertain whether additional information may be necessary to assist the board in determining the patient's need for surrogate decision making and in determining whether the patient's best interests will be served by consenting to or refusing medical care on the patient's behalf. The board chairperson or designee may:

a. Request and shall, not withstanding any other law to the contrary, be entitled to receive from any physician, hospital or health care facility or person licensed to render health care, any information which is relevant to the patient's need for surrogate decision making or for the proposed medical care. Such information may include, among other things: information regarding the patient's preferences regarding medical care; facts regarding the patient's attorney-in-fact, guardian, spouse, adult child, parent, or an adult sibling; facts and professional opinions regarding the patient's inability to consent to or refuse medical care; and facts and professional opinions regarding whether the proposed medical care is in the patient's best interests; the board chairperson or designee shall maintain the confidentiality of records as required by Iowa Code chapters 22, 141, and 228, and 42 Code of Federal Regulations Part 2, as of January 1, 1992, or any other applicable confidentiality law provision;

b. Consult with any other person who might assist in such a determination of the best interests of the patient, including ascertainment of the personal beliefs and values of the patient.

641—85.6(135) Panel appointment and procedures.

85.6(1) When an application is filed, the chairperson shall appoint a panel to handle the case and designate a panel chairperson. The panel shall consist of at least three members with at least one from each category listed in rule 85.3(135). A person shall not participate on a panel for a case when that person has a conflict of interest. The panel may include the entire local board.

85.6(2) Upon appointment of the panel, the board chairperson or designee shall provide a copy of the application to each panel member accompanied by a notice of the time, place and date of the panel hearing on the application. The notice of the hearing shall also be provided to the patient, the person who filed the application, and any other interested party, if known. The notice shall inform the recipients of the procedures of the panel, including the opportunity for the recipient to be present and to be heard. The notice shall be given no less that 24 hours prior to the scheduled time for the hearing.

85.6(3) The general procedures of the hearing are as follows:

a. The panel shall be empowered to administer oaths and take testimony from any person who might assist the panel in making its decision. It shall also be empowered to conduct its proceeding via telephone conference calls in appropriate cases, unless someone objects and requests a face-to-face hearing.

b. A record of the deliberations and proceedings of the panel shall be made and retained for ten years. Such record shall include any information, record, assessment or consultation submitted to or considered by the panel.

c. The panel and each member of the local board shall maintain the confidentiality of records as required by Iowa Code chapters 22, 141, and 228 and 42 Code of Federal Regulations Part 2 or any other applicable confidentiality law provision.

d. The patient shall have the right to be present at the hearing and the right to express feelings to the panel orally or in writing and the right to designate someone to represent the patient before the panel.

e. If at any time during the pendency or prior to initiation of treatment, an attorney-in-fact, guardian, spouse, adult child, parent or an adult sibling is reasonably available, willing and able to consent to or refuse such care on the patient's behalf, objects to the panel acting upon the application, the proceedings regarding such patient shall cease. A record of any such person's objection shall be included as part of the record as provided for by this section.

f. The panel shall issue its written decision within 24 hours after the conclusion of the hearing. The decision shall state when the decision shall become effective and shall include a statement describing the right of appeal. The written decision shall be issued to the necessary persons, including the patient.

g. If the decision is hand-delivered, it shall not be effective sooner than 24 hours after the written decision is delivered to the patient or the person designated by the patient in 85.6(3)*"e."* If the decision is sent by certified mail, return receipt requested, it shall not be effective sooner than 48 hours after it is mailed. The date, time, and method of delivery of the decision to the patient shall be noted in the record.

h. A panel determination that a patient is in need of surrogate decision making for the proposed medical care shall not be valid for any future medical care and shall not be construed or deemed valid for any other purpose or for any other future medical care unless the determination explicitly applies to related or continuing treatment necessitated by the original treatment. No panel determination shall be valid after 60 days from its effective date unless the determination explicitly states otherwise.

i. All information, records, assessments or consultations submitted to or considered by the panel or board and the panel and board deliberations are confidential as required by Iowa Code chapters 22, 141, and 228 and 42 Code of Federal Regulations Part 2 or any other applicable confidentiality law provision.

641—85.7(135) Panel determination of need for surrogate decision making. The panel's determination of the patient's need for surrogate decision making shall be made in accordance with the following provisions:

85.7(1) The panel shall decide based upon a preponderance of evidence whether the patient is in need of surrogate decision making by determining that the patient: lacks the ability to consent to or refuse the proposed medical care and does not have an attorney-in-fact, guardian, spouse, adult child, parent, or an adult sibling who is reasonably available, willing and able to make such a decision.

The method of determining patient's capability to consent to or refuse care shall include examination of patient by a licensed physician with a written report to the local board.

When practical, the panel members shall personally interview and observe the patient as a part of the hearing. If a personal appearance by the patient before the panel is not practical, then either the panel chairperson shall designate a member of the panel to interview and observe the patient prior to the hearing or the panel shall require one of the following:

1. Written report of examination by psychiatrist.
2. Written report of examination by psychologist.
3. Written report of examination by physician not involved in case.
4. Written report from a department of human services investigator involved with patient.
5. Written report from long-term care case management project.

85.7(2) In making the determination of whether the patient lacks the capacity to consent to or refuse the proposed medical care, the panel or board shall consider whether the patient is unable to adequately understand and appreciate the nature and consequences of the proposed medical care.

85.7(3) A majority of the panel members must vote in the affirmative that the patient is in need of surrogate decision making or the patient will be deemed not to need surrogate decision making.

85.7(4) A panel determination that a patient is in need of surrogate decision making shall not be construed or deemed to be a legal determination that such person is incompetent.

85.7(5) In the event the panel or board has determined the patient to be capable of decision making, then the patient's consent to or refusal of such treatment, if given, shall constitute valid consent or refusal. No other consent shall be required by a provider of health services.

641—85.8(135) Panel determination regarding proposed medical care decision. If a patient has been determined by the panel to be in need of surrogate decision making, the panel's determination regarding the proposed medical care shall be made in accordance with the following provisions:

85.8(1) The past or present expression of wishes by the patient will be presumed valid unless clearly overcome by other evidence. The patient's autonomy should always be respected.

85.8(2) If there is no clear preference by the patient, the panel shall make the determination whether the proposed medical care is in the best interests of the patient based upon a preponderance of the evidence by considering the following standards:

a. The burdens of the treatment to the patient in terms of pain and suffering outweighing the benefits or whether the proposed treatment would merely prolong the patient's suffering and not provide any net benefit;

b. The degree, expected duration, and constancy of pain with and without treatment, and the possibility that the pain could be mitigated by less intrusive forms of medical treatment including the administration of medications;

c. The likely prognosis, expectant level of functioning, degree of humiliation and dependency with or without the proposed medical care; and

d. Evaluation of treatment options, including nontreatment, and their benefits and risks compared to those of the proposed medical care.

85.8(3) A majority of the panel members must vote in the affirmative for a valid determination of consent to or refusal of medical care on behalf of the patient.

85.8(4) The panel determination consenting to or refusing medical care shall constitute valid consent to or refusal of such treatment in the same manner and to the same extent as if the patient were able to consent or refuse on the patient's own behalf.

85.8(5) The panel's consent to medical care shall state that any tissues or parts surgically removed may be disposed of or preserved by the provider of health services in accordance with customary practice.

641—85.9(135) Right of appeal.

85.9(1) The patient, the person who filed the application, or a correspondent may appeal the local board's decision to the department. The appeal must be made before the date and time that the consent becomes effective. The person appealing shall notify the local board or the department of the appeal. The notice of the appeal shall be in writing or by telephone followed by a written appeal to the department. If the appeal is initially made by telephone, the written appeal to the department shall be postmarked within 48 hours of the telephone notice. The written appeal shall state the reason for the appeal. If the initial appeal is made to the local board, the local board representative shall immediately notify the department and the health care provider. If the initial appeal is made to the department, the department representative shall immediately notify the local board and the health care provider.

85.9(2) Upon receipt of the notice of appeal, the local board shall immediately provide a copy of the record of the case to the department. The department shall review the record to determine whether the determination by the local panel is supported by substantial evidence. The department shall also review new information which is submitted regarding the case. The department's decision shall be based on a review of the record and a review of any new information and shall be made in accordance with the provisions for local panel determination in rules 641—85.7(135) and 641—85.8(135). The department's decision shall be promptly sent by certified mail, return receipt requested, or otherwise provided by any other means that will provide more timely or reliable written notice to: the patient, the person filing the appeal, the person who filed the application and the chairperson of the local board. If any of these persons are dissatisfied with the department's decision, an appeal may be taken in the manner provided by Iowa Code chapter 17A.

[**ARC 0061C**, IAB 4/4/12, effective 5/9/12]

641—85.10(135) Records and reports. Each fiscal year, prior to October 1, the local board shall submit an annual report to the department on forms provided by the department. The report shall include summary information regarding the number, nature and disposition of applications filed with the local

board in the preceding year. It shall also include a list of the local board members and officers for the new year and such other information as the department may deem necessary. Authorized representatives of the department shall have access to all records of the local boards. All record information which is excluded from public access and inspection pursuant to Iowa Code chapter 22, 141A or 228 and 42 Code of Federal Regulations Part 2, or any other confidentiality law provision shall be respected by the department.
[**ARC 0061C**, IAB 4/4/12, effective 5/9/12]

641—85.11(135) Liability. The local substitute medical decision-making board and its members shall not be held liable, jointly or separately, for any actions or omissions taken or made in the official discharge of their duties, except those acts or omissions constituting willful or wanton misconduct.
[**ARC 0061C**, IAB 4/4/12, effective 5/9/12]

These rules are intended to implement Iowa Code section 135.29.

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[1] Effective date of 7/1/92 delayed 70 days by the Administrative Rules Review Committee at its meeting held June 10, 1992; delay lifted by the Committee at its meeting held July 15, 1992.

CHAPTER 131
EMERGENCY MEDICAL SERVICES—PROVIDER EDUCATION/TRAINING/CERTIFICATION

641—131.1(147A) Definitions. For the purpose of these rules, the following definitions shall apply:

"Advanced emergency medical technician" or *"AEMT"* means an individual who has successfully completed a course of study based on the United States Department of Transportation's Advanced Emergency Medical Technician Instructional Guidelines (January 2009), has passed the NREMT practical and cognitive examinations for the AEMT, and is currently certified by the department as an AEMT.

"Automated external defibrillator" or *"AED"* means an external semiautomatic device that determines whether defibrillation is required.

"Candidate" means an individual who has successfully completed a course of study at an EMR, EMT, AEMT or paramedic or other level certified by the department and who has been recommended by a training program for NREMT certification examination.

"CECBEMS" means the continuing education coordinating board for emergency medical services.

"CEH" means continuing education hour, which is based upon a minimum of 50 minutes of training per hour.

"Certification period" means the length of time an emergency medical care provider certificate is valid. The certification period shall be for two years from initial issuance or from renewal, unless otherwise specified on the certificate or unless sooner suspended or revoked.

"Certification status" means a condition placed on an individual certificate for identification as active, deceased, denied, dropped, expired, failed, hold, idle, inactive, incomplete, pending, probation, restricted, retired, revoked, surrendered, suspended, or temporary.

"Continuing education" means department-approved training which is obtained by a certified emergency medical care provider to maintain, improve, or expand relevant skills and knowledge and to satisfy renewal of certification requirements.

"Course completion date" means the date of the final classroom session of an emergency medical care provider course.

"Course coordinator" means an individual who has been assigned by the training program to coordinate the activities of an emergency medical care provider course.

"CPR" means training and successful course completion in cardiopulmonary resuscitation, AED, and obstructed airway procedures for all age groups according to recognized national standards.

"Critical care paramedic" or *"CCP"* means a currently certified paramedic specialist who has successfully completed a critical care course of instruction approved by the department and has received endorsement from the department as a critical care paramedic.

"Current course completion" means written recognition given for training and successful course completion of CPR with an expiration date or a recommended renewal date that exceeds the current date.

"Department" means the Iowa department of public health.

"Director" means the director of the Iowa department of public health.

"DOT" means the United States Department of Transportation.

"Emergency medical care" means such medical procedures as:

1. Administration of intravenous solutions.
2. Intubation.
3. Performance of cardiac defibrillation and synchronized cardioversion.
4. Administration of emergency drugs as provided by protocol.
5. Any medical procedure authorized by subrule 131.3(3).

"Emergency medical care provider" means an individual who has been trained to provide emergency and nonemergency medical care at the EMR, EMT, AEMT, paramedic or other certification level recognized by the department before 2011 and who has been issued a certificate by the department.

"Emergency medical responder" or *"EMR"* means an individual who has successfully completed a course of study based on the United States Department of Transportation's Emergency Medical Responder Instructional Guidelines (January 2009), has passed the NREMT practical and cognitive examinations for the EMR, and is currently certified by the department as an EMR.

"Emergency medical services" or *"EMS"* means an integrated medical care delivery system to provide emergency and nonemergency medical care at the scene or during out-of-hospital patient transportation in an ambulance.

"Emergency medical technician" or *"EMT"* means an individual who has successfully completed a course of study based on the United States Department of Transportation's Emergency Medical Technician Instructional Guidelines (January 2009), has passed the NREMT practical and cognitive examinations for the EMT, and is currently certified by the department as an EMT.

"Emergency medical technician-ambulance" or *"EMT-A"* means an individual who has successfully completed the 1984 United States Department of Transportation's Emergency Medical Technician-Ambulance curriculum, has passed the department's approved written and practical examinations, and is currently certified by the department as an EMT-A.

"Emergency medical technician-basic" or *"EMT-B"* means an individual who has successfully completed the current United States Department of Transportation's Emergency Medical Technician-Basic curriculum and department enhancements, has passed the department's approved written and practical examinations, and is currently certified by the department as an EMT-B.

"Emergency medical technician-defibrillation" or *"EMT-D"* means an individual who has successfully completed an approved program which specifically addresses manual or automated defibrillation, has passed the department's approved written and practical examinations, and is currently certified by the department as an EMT-D.

"Emergency medical technician-intermediate" or *"EMT-I"* means an individual who has successfully completed an EMT-Intermediate curriculum approved by the department, has passed the department's approved written and practical examinations, and is currently certified by the department as an EMT-I.

"Emergency medical technician-paramedic" or *"EMT-P"* means an individual who has successfully completed the current United States Department of Transportation's EMT-Intermediate curriculum (1999) or the 1985 or earlier DOT EMT-P curriculum, has passed the department's approved written and practical examinations, and is currently certified by the department as an EMT-P.

"EMS advisory council" means the council appointed by the director, pursuant to Iowa Code chapter 147A, to advise the director and develop policy recommendations concerning regulation, administration, and coordination of emergency medical services in the state.

"EMS evaluator" or *"EMS-E"* means an individual who has successfully completed an EMS evaluator curriculum approved by the department and is currently endorsed by the department as an EMS-E.

"EMS instructor" or *"EMS-I"* means an individual who has successfully completed an EMS instructor curriculum approved by the department and is currently endorsed by the department as an EMS-I.

"Endorsement" means an approval granted by the department authorizing an individual to serve as an EMS-I, EMS-E or CCP.

"First responder" or *"FR"* means an individual who has successfully completed the current United States Department of Transportation's first responder curriculum and department enhancements, has passed the department's approved written and practical examinations, and is currently certified by the department as an FR.

"First responder-defibrillation" or *"FR-D"* means an individual who has successfully completed an approved program that specifically addresses defibrillation, has passed the department's approved written and practical examinations, and is currently certified by the department as an FR-D.

"Good standing" means that a student or candidate is in compliance with these rules and training program requirements.

"Idle" means the status of a lower certification level when a higher certification level is held.

"Inactive" means the status of a certification level when an individual requests inactive status or moves from a higher certification level to a lower certification level that was previously idle.

"NCA" means North Central Association of Colleges and Schools.

"NREMT" means National Registry of Emergency Medical Technicians.

"Out-of-state student" means any individual participating in clinical or field experience as a student in an approved out-of-state training program.

"Out-of-state training program" means an EMS program located outside the state of Iowa that is approved by the authorizing agency of the program's home state to conduct initial EMS training for EMR, EMT, AEMT, paramedic or other level certified by the department.

"Outreach course coordinator" means an individual who has been assigned by the training program to coordinate the activities of an emergency medical care provider course held outside the training program facilities.

"Paramedic" means an individual who has successfully completed a course of study based on the United States Department of Transportation's Paramedic Instructional Guidelines (January 2009), has passed the NREMT practical and cognitive examination for the paramedic, and is currently certified by the department as a paramedic.

"Paramedic specialist" or *"PS"* means an individual who has successfully completed the current United States Department of Transportation's EMT-Paramedic curriculum (1999) or equivalent, has passed the department's approved written and practical examinations, and is currently certified by the department as a paramedic specialist.

"Patient" means an individual who is sick, injured, or otherwise incapacitated.

"Physician" means an individual licensed under Iowa Code chapter 148.

"Physician assistant" or *"PA"* means an individual licensed pursuant to Iowa Code chapter 148C.

"Physician designee" means a registered nurse licensed under Iowa Code chapter 152 or any physician assistant licensed under Iowa Code chapter 148C and approved by the board of physician assistants. The physician designee acts as an intermediary for a supervising physician in accordance with written policies and protocols in directing the care provided by emergency medical care providers.

"Preceptor" means an individual who has been assigned by the training program, clinical facility or service program to supervise students while the students are completing their clinical or field experience. A preceptor must be an emergency medical care provider certified at the level at which the preceptor is providing supervision or at a higher level or must be licensed as a registered nurse, physician assistant or physician.

"Primary instructor" means an individual who is responsible for teaching the majority of an emergency medical care provider course.

"Protocols" means written directions and orders consistent with the department's standard of care that are to be followed by an emergency medical care provider in emergency and nonemergency situations. Protocols must be approved by the service program's medical director and address the care of both adult and pediatric patients.

"Registered nurse" or *"RN"* means an individual licensed pursuant to Iowa Code chapter 152.

"Service program" or *"service"* means any medical care ambulance service or nontransport service that has received authorization from the department.

"Service program area" means the geographic area of responsibility served by any given ambulance or nontransport service program.

"Student" means any individual enrolled in a training program and participating in the didactic, clinical, or field experience portion of the program.

"Training program" means an Iowa college approved by the North Central Association of Colleges and Schools or an Iowa hospital authorized by the department to conduct emergency medical care training.

"Training program director" means an appropriate health care professional (full-time educator or practitioner of emergency or critical care) assigned by the training program to direct the operation of the training program.

"Training program medical director" means a physician licensed under Iowa Code chapter 148 who is responsible for directing an emergency medical care training program.
[**ARC 9443B**, IAB 4/6/11, effective 8/1/11]

641—131.2(147A) Emergency medical care providers—requirements for enrollment in training programs. To be enrolled in an EMS training program course leading to certification by the department, an applicant shall:

1. Be at least 17 years of age at the time of enrollment.
2. Have a high school diploma or its equivalent if enrolling in an AEMT or paramedic course.
3. Be able to speak, write and read English.
4. Hold a current course completion card in CPR if enrolling in an EMT, AEMT or paramedic course.
5. Be currently certified, as a minimum, as an EMT if enrolling in an AEMT or paramedic course. If an applicant is currently nationally registered but not certified in Iowa, the applicant must submit an endorsement application to the department within 14 days after the course start date.
6. Be a current emergency medical care provider, RN, PA, or physician and submit a recommendation in writing from an approved EMS training program if enrolling in an EMS instructor course.
7. Be currently certified as a paramedic if enrolling in a CCP course.

[**ARC 9443B**, IAB 4/6/11, effective 8/1/11]

641—131.3(147A) Emergency medical care providers—authority.

131.3(1) Authority of emergency medical care personnel. An emergency medical care provider who holds an active certification issued by the department may:

a. Render, via on-line medical direction, emergency and nonemergency medical care in those areas for which the emergency medical care provider is certified as part of an authorized service program:

(1) At the scene of an emergency;
(2) During transportation to a hospital;
(3) While in the hospital emergency department;
(4) Until patient care is directly assumed by a physician or by authorized hospital personnel; and
(5) During transfer from one medical care facility to another or to a private home.

b. Function in any hospital or any other entity in which health care is ordinarily provided only when under the direct supervision of a physician when:

(1) Enrolled as a student in, and approved by, a training program;
(2) Fulfilling continuing education requirements;
(3) Employed by or assigned to a hospital or other entity in which health care is ordinarily provided only when under the direct supervision of a physician as a member of an authorized service program, or in an individual capacity, by rendering lifesaving services in the facility in which employed or assigned pursuant to the emergency medical care provider's certification and under direct supervision of a physician, physician assistant, or registered nurse. An emergency medical care provider shall not routinely function without the direct supervision of a physician, physician assistant, or registered nurse. However, when the physician, physician assistant, or registered nurse cannot directly assume emergency care of the patient, the emergency medical care provider may perform, without direct supervision, emergency medical care procedures for which certified, if the life of the patient is in immediate danger and such care is required to preserve the patient's life;
(4) Employed by or assigned to a hospital or other entity in which health care is ordinarily provided only under the direct supervision of a physician, as a member of an authorized service program, or in an individual capacity, to perform nonlifesaving procedures for which certified and designated in a written job description. Such procedures may be performed after the patient is observed by and when the emergency medical care provider is under the supervision of the physician, physician assistant, or registered nurse, including when the registered nurse is not acting in the capacity of a physician designee, and where the procedure may be immediately abandoned without risk to the patient.

131.3(2) When emergency medical care personnel are functioning in a capacity identified in 131.3(1)*"a,"* they may perform emergency and nonemergency medical care without contacting a supervising physician or physician designee if written protocols have been approved by the service program medical director which clearly identify when the protocols may be used in lieu of voice contact.

131.3(3) Scope of practice.

a. Emergency medical care providers shall provide only those services and procedures that are authorized within the scope of practice for which they are certified.

b. Scope of Practice for Iowa EMS Providers (July 2011) is hereby incorporated and adopted by reference for emergency medical care providers. For any differences that may occur between the Scope of Practice adopted by reference and these administrative rules, the administrative rules shall prevail.

c. The department may grant a variance for changes to the Scope of Practice that have not yet been adopted by reference in these rules. A variance to these rules may be granted by the department pursuant to 641—subrule 132.14(1).

d. Scope of Practice for Iowa EMS Providers is available through the Iowa Department of Public Health, Bureau of EMS, Lucas State Office Building, Des Moines, Iowa 50319-0075, or the bureau of EMS Web site (www.idph.state.ia.us/ems).

131.3(4) The department may approve emergency medical pilot project(s) on a limited basis. Requests for a pilot project application shall be made to the department.

131.3(5) An emergency medical care provider who has knowledge of an emergency medical care provider, service program or training program that has violated Iowa Code chapter 147A or these rules shall report such information to the department within 30 days.

[**ARC 9443B**, IAB 4/6/11, effective 8/1/11; **ARC 0062C**, IAB 4/4/12, effective 5/9/12]

641—131.4(147A) Emergency medical care providers—certification, renewal standards, procedures, continuing education, and fees.

131.4(1) *Student application and candidate examination.*

a. Applicants shall complete the EMS Student Registration within 14 days after the beginning of the course. The EMS Student Registration shall be completed via the bureau of EMS Web site at www.idph.state.ia.us/ems.

b. Upon satisfactory completion of the course and all training program requirements, including payment of appropriate fees, a candidate shall be recommended by a training program to take the appropriate NREMT certification examination. A candidate is not eligible to continue functioning as a student in the clinical and field settings and must obtain state certification to perform appropriate skills.

c. A candidate shall submit an EMS Certification Application form to the department. EMS Certification Application forms are provided by the department.

d. When a student's EMS Student Registration or a candidate's EMS Certification Application is referred to the department for investigation or when a student or candidate is otherwise under investigation by the department, the individual shall not be eligible for certification, and the practical examination results will not be confirmed with the NREMT, until the individual is approved by the department.

e. The fee for certification as an emergency medical care provider is $30, payable to the Iowa Department of Public Health. This nonrefundable fee shall be paid prior to a candidate's receiving certification.

f. A candidate must successfully complete the NREMT practical and cognitive examinations to be eligible for state certification.

g. The practical examination may be conducted by an authorized training program and must be conducted according to the policies and procedures of the NREMT.

h. A candidate must meet all certification requirements within two years of the initial course completion date. If a candidate is unable to complete the requirements within two years due to medical reasons or military obligation, an extension may be granted upon submission of a signed statement from an appropriate medical or military authority and approval by the department.

i. Examination scores shall be confidential except that they may be released to the training program that provided the training or to other appropriate state agencies or released in a manner which does not permit the identification of an individual.

j. An applicant for EMS-I endorsement shall successfully complete an EMS-Instructor curriculum approved by the department.

131.4(2) *Multiple certificates and renewal.*

a. The department shall consider the highest level of certification attained to be active. Any lower levels of certification shall be considered idle.

b. A lower-level certificate may be issued if the individual fails to renew the higher level of certification or voluntarily chooses to move from a higher level to a lower level. To be issued a certificate in these instances, an individual shall:

(1) Complete all applicable continuing education requirements for the lower level during the certification period and submit a change of status request, available through the Iowa Department of Public Health, Bureau of EMS, Lucas State Office Building, Des Moines, Iowa 50319-0075, or the bureau of EMS Web site (www.idph.state.ia.us/ems).

(2) Complete and submit to the department an EMS Affirmative Renewal of Certification Application and the applicable fee.

(3) Complete the reinstatement process in 131.4(4)*"f"* if renewal of the higher level is requested later.

c. A citation and warning, denial, probation, restriction, suspension or revocation imposed upon an individual certificate holder by the department shall be considered applicable to all certificates issued to that individual by the department.

131.4(3) *Certification transition.*

a. An individual certified as a first responder based on the 1996 National Standard Curriculum for First Responders, an EMT-B, an EMT-I, an EMT-P or a PS shall complete the following certification transition requirements. Transition documents for each level are available through the Iowa Department of Public Health, Bureau of EMS, Lucas State Office Building, Des Moines, Iowa 50319-0075, or the bureau of EMS Web site (www.idph.state.ia.us/ems).

b. FR transition to EMR.

(1) The FR shall complete training identified in the FR to EMR Documentation (January 2011).

(2) The FR shall verify completion of training on the Affirmative Renewal of Certification Application by the certification's regular expiration date prior to October 1, 2014.

(3) An FR who does not complete the transition requirements will not satisfy the renewal requirements for the certification period immediately prior to October 1, 2014.

c. EMT-B transition to EMT.

(1) The EMT-B shall complete training identified in the EMT-B to EMT Documentation (January 2011).

(2) The EMT-B shall verify completion of training on the Affirmative Renewal of Certification Application by the certification's regular expiration date prior to April 1, 2015.

(3) An EMT-B who does not complete the transition requirements will not satisfy the renewal requirements for the certification period immediately prior to April 1, 2015.

d. EMT-I transition to AEMT.

(1) The EMT-I shall submit documentation of training identified in the EMT-I to AEMT Documentation (January 2011) to the department.

(2) The EMT-I shall successfully complete the NREMT computer-based AEMT examination.

(3) A provider certified as an EMT-I who has not completed the transition to AEMT will be issued an EMT certification on April 1, 2016.

e. EMT-P transition to paramedic.

(1) The EMT-P shall submit documentation of training identified in the EMT-P to Paramedic Documentation (January 2011) to the department.

(2) The EMT-P shall successfully complete the NREMT computer-based paramedic examination.

(3) A provider certified as an EMT-P who has not completed the transition to paramedic will be issued an AEMT certification on April 1, 2018.

f. PS transition to paramedic.

(1) The PS shall complete training identified in the PS to Paramedic Documentation (January 2011).

(2) The PS shall verify completion of training on the Affirmative Renewal of Certification Application by the certification's regular expiration date prior to April 1, 2015.

(3) A PS who does not complete the transition requirements will not satisfy the renewal requirements for the certification period immediately prior to April 1, 2015.

131.4(4) *Renewal of certification.*

a. A certificate shall be valid for two years from issuance unless specified otherwise on the certificate or unless sooner suspended or revoked.

b. All continuing education requirements shall be completed during the certification period prior to the certificate's expiration date. Failure to complete the continuing education requirements prior to the expiration date shall result in an expired certification, unless the emergency medical care provider requests an extension as described in 131.4(11)*"b."*

c. An emergency medical care provider shall submit the EMS Affirmative Renewal of Certification Application to the department within 90 days prior to the expiration date. Failure to submit a renewal application to the department within 90 days prior to the expiration date (date of submission is based upon the postmark date) shall cause the current certification to expire.

d. An emergency medical care provider shall not function with an expired certification.

e. An emergency medical care provider who completes the required continuing education during the certification period but fails to submit the EMS Affirmative Renewal of Certification Application within 90 days prior to the expiration date shall be required to submit a late fee of $30 (in addition to the renewal fee) and complete the audit process pursuant to 131.4(5)*"i"* to obtain renewal of certification.

f. An emergency medical care provider who has not completed the required continuing education during the certification period or who is seeking to reinstate an expired, inactive, or retired certificate shall:

(1) Complete a refresher course or equivalent approved by the department.

(2) Meet all applicable eligibility requirements.

(3) Submit an EMS Reinstatement Application and the applicable fees to the department.

(4) Pass the appropriate practical and cognitive certification examinations.

g. An emergency medical care provider may request an inactive or retired status for a certificate. The request must be made by submitting a change of status request, available through the Iowa Department of Public Health, Bureau of EMS, Lucas State Office Building, Des Moines, Iowa 50319-0075, or the bureau of EMS Web site (www.idph.state.ia.us/ems). Reinstatement of an inactive or retired certificate shall be made pursuant to 131.4(4)*"f."* A request for inactive or retired status, when accepted in connection with a disciplinary investigation or proceeding, has the same effect as an order of revocation.

h. An emergency medical care provider shall be deemed to have complied with the continuing education requirements during periods in which the provider serves honorably on active duty in the military services or for periods in which the provider is a government employee working as an emergency medical care provider and assigned to duty outside the United States. The emergency medical care provider must submit the Affirmative Renewal of Certification Application, all appropriate fees and documentation of assignment.

131.4(5) *Continuing education renewal standards.* The following standards apply to renewal through continuing education:

a. An applicant shall sign and submit an Affirmative Renewal of Certification Application provided by the department and submit the applicable fee within 90 days prior to the certificate's expiration date.

b. An applicant shall complete the continuing education requirements, including current course completion in CPR, during the certification period for the following emergency medical care provider levels:

(1) EMR, FR, FR-D—12 hours of approved continuing education.
(2) EMT, EMT-A, EMT-B, EMT-D—24 hours of approved continuing education.
(3) AEMT, EMT-I—36 hours of approved continuing education.
(4) EMT-P—48 hours of approved continuing education.
(5) PS, paramedic—60 hours of approved continuing education.
(6) EMS-I—Attend at least one EMS-I workshop sponsored by the department.
(7) CCP—8 hours of approved CCP core curriculum topics.

c. At least 50 percent of the required hours for renewal shall be formal continuing education including, but not limited to, refresher programs, seminars, lecture programs, scenario-based programs, conferences, and Internet-delivered courses approved by CECBEMS and shall meet the criteria established in 131.4(6)*"d."*

d. Up to 50 percent of the required continuing education hours may be made up of any of the following:
(1) Nationally recognized EMS-related courses.
(2) EMS self-study courses.
(3) Medical director or designee case reviews.
(4) Clinical rounds with medical team (grand rounds).
(5) Working with students as an EMS field preceptor.
(6) Hospital or nursing home clinical performance.
(7) Skills workshops/maintenance.
(8) Community public information education projects.
(9) Emergency driver training.
(10) EMS course audits.
(11) Injury prevention or wellness initiatives.
(12) EMS service operations, e.g., management programs, continuous quality improvement.
(13) EMS system development meetings that occur at the county, regional or state level.
(14) Disaster preparedness.
(15) Emergency runs/responses as a volunteer member of an authorized EMS service program (primary attendant).
(16) EMS-Instructor development.

e. Additional hours may be allowed for any of the following (maximum):
(1) CPR—2 hours.
(2) Disaster drill—4 hours.
(3) Rescue—4 hours.
(4) Hazardous materials—8 hours.
(5) Practical examination evaluator—4 hours.
(6) Topics outside the provider's core curriculum—8 hours.

f. With training program approval, a person who is not enrolled in an emergency medical care provider course may audit the course for CEHs.

g. The certificate holder must notify the department within 30 days of a change in address.

h. The certificate holder shall maintain a file containing documentation of CEHs accrued during each certification period for four years from the end of each certification period.

i. A group of individual certificate holders will be audited for each certification period. Certificate holders to be audited will be chosen in a random manner or at the discretion of the bureau of EMS. Falsifying reports or failure to comply with the audit request may result in formal disciplinary action. Certificate holders who are audited will be required to submit an Audit Report Form provided by the department within 45 days of the request. If audited, the certificate holders must provide the following information:
(1) Date of program.
(2) Program sponsor number.
(3) Title of program.
(4) Number of approved hours.

(5) Appropriate supervisor signatures if clinical or practical evaluator hours are claimed.

j. An EMS instructor who teaches EMS initial or continuing education courses may use those courses for renewal as approved under subrule 131.4(6).

131.4(6) *Continuing education approval.* The following standards shall be applied for approval of continuing education:

a. Required CEHs identified in 131.4(5)*"c"* shall be approved by the department, CECBEMS, or an authorized EMS training program, using a sponsor number assignment system approved by the department.

b. Optional CEHs identified in 131.4(5)*"d"* and 131.4(5)*"e"* require no formal sponsor number; however, CEHs awarded shall be verified by an authorized EMS training program, a national EMS continuing education accreditation entity, a service program medical director, an appropriate community sponsor, or the department. Documentation of CEHs awarded shall include the date and title of the program or event, the number of hours approved, and the applicable signatures.

c. Courses in physical, social or behavioral sciences offered by accredited colleges and universities are approved for CEHs and need no further approval. One quarter credit equals 10 hours. One semester credit equals 15 hours.

d. Courses approved as formal education must meet the following criteria:

(1) Involve live interaction with an instructor or be an Internet-delivered course approved by CECBEMS; and

(2) Be based on the appropriate department curricula for EMS providers and include one or more of the following topic areas: airway management, patient assessment, trauma assessment and management, medical assessment and management, behavioral emergencies, obstetrics, gynecology, pediatrics, or patient care record documentation.

e. Programs developed and delivered by the department may be approved for formal education.

131.4(7) *Out-of-state continuing education.* Out-of-state continuing education courses will be accepted for CEHs if they meet the criteria in subrule 131.4(5) and have been approved for emergency medical care personnel in the state in which the courses were held. A copy of course completion certificates (or other verifying documentation) shall, upon request, be submitted to the department with the EMS Affirmative Renewal of Certification Application.

131.4(8) *Fees.* The following fees shall be collected by the department and shall be nonrefundable:

a. FR, EMR, EMT-B, EMT, EMT-I, AEMT, EMT-P, PS and paramedic certification fee—$30.

b. Certification renewal fees:

(1) FR, EMR, EMT-B, and EMT—no fee.

(2) EMT-I, AEMT—$10.

(3) EMT-P, PS and paramedic—$25.

A certification renewal fee is refundable if the applicant's certification renewal status is not posted on the bureau of EMS Web site in the certification database within ten working days from the date the department receives the completed renewal application.

c. Endorsement certification fee—$50.

d. Reinstatement fee—$30.

e. Late fee—$30.

f. Duplicate/replacement card—$10.

g. Returned check—$20.

h. Extension fee—$50.

131.4(9) *Certification through reciprocity.* An individual currently certified by the NREMT must also possess a current Iowa certificate to be considered certified in this state. The department shall contact the NREMT to verify certification or registry and good standing.

a. To receive Iowa certification, the individual shall:

(1) Complete and submit the EMS Reciprocity Application available from the department.

(2) Provide verification of current certification in another state, if applicable, and registration with the NREMT.

(3) Provide verification of current course completion in CPR.

(4) Meet all other applicable eligibility requirements necessary for Iowa certification pursuant to these rules.

(5) Submit all applicable fees to the department.

b. An individual certified through reciprocity shall satisfy the renewal and continuing education requirements set forth in subrule 131.4(4) to renew Iowa certification.

131.4(10) *National registration in lieu of continuing education.*

a. An emergency medical care provider who is certified in Iowa and is registered with the NREMT may renew certification by meeting the NREMT reregistration requirements.

b. The emergency medical care provider shall submit the NREMT Registration in Lieu of Continuing Education Application, available through the Iowa Department of Public Health, Bureau of EMS, Lucas State Office Building, Des Moines, Iowa 50319-0075, or the bureau of EMS Web site (www.idph.state.ia.us/ems), to the department, with proof of NREMT registration exceeding the current certification expiration date, within 90 days prior to the expiration date.

131.4(11) *Extension of certification.*

a. If an emergency medical care provider is unable to complete the required continuing education during the certification period due to a medical reason, an extension of certification may be issued upon submission of a signed statement from an appropriate medical provider and approval by the department. The statement must include information concerning the reason the emergency medical care provider could not complete the continuing education requirements, the time period affected, and the length of time requested for extension.

b. If an emergency medical care provider is unable to attain all continuing education requirements within the certification period, a 45-day extension may be granted. To complete the extension process, the provider shall:

(1) Submit a Request for Extension Application, available through the Iowa Department of Public Health, Bureau of EMS, Lucas State Office Building, Des Moines, Iowa 50319-0075, or the bureau of EMS Web site (www.idph.state.ia.us/ems), at least 7 days prior to the expiration date, but no more than 90 days prior to the expiration date, and a $50 extension fee.

(2) Be given 45 days from the current expiration date to complete continuing education requirements.

(3) Submit the EMS Affirmative Renewal of Certification Application, with all applicable renewal fees, to the department prior to the extended expiration date (date of submission is based on the postmark date).

(4) Not use continuing education completed during the extension period in the subsequent renewal period.

[**ARC 9443B**, IAB 4/6/11, effective 8/1/11]

641—131.5(147A) Training programs—standards, application, inspection and approval.

131.5(1) *Education standards.*

a. A training program shall use the applicable United States Department of Transportation's Education Standards (January 2009) for courses leading to certification.

b. A training program shall use the EMS-Instructor curriculum approved by the department for courses leading to the EMS-I endorsement.

c. A training program shall use the Iowa CCP curriculum (November 2001) for courses leading to the CCP endorsement.

d. A training program may waive portions of the required emergency medical care provider training for individuals certified as emergency medical care providers or licensed in other health care professions including, but not limited to, nursing, physician assistant, respiratory therapist, dentistry, and military. The training program shall document equivalent training and what portions of the course have been waived for equivalency.

131.5(2) *Clinical or field experience resources.* If clinical or field experience resources are located outside the framework of the training program, written agreements for such resources shall be obtained by the training program.

131.5(3) *Facilities.*

a. A training program shall ensure adequate classroom, laboratory, and practice space to conduct the training program. A library with reference materials on emergency and critical care shall also be available.

b. A training program shall ensure opportunities for the student to accomplish the appropriate skill competencies in the clinical environment. The following hospital units shall be available for clinical experience for each training program as required in approved education standards pursuant to subrule 131.5(1):

(1) Emergency department;
(2) Intensive care unit or coronary care unit or both;
(3) Operating room and recovery room;
(4) Intravenous or phlebotomy team or other method to obtain IV experience;
(5) Pediatric unit;
(6) Labor and delivery suite and newborn nursery; and
(7) Psychiatric unit.

c. A training program shall ensure opportunities for the student to accomplish the appropriate skill competencies in the field environment. The training program shall use an appropriate emergency medical care service program to provide field experience as required in approved education standards pursuant to subrule 131.5(1).

d. A training program shall have liability insurance and shall offer liability insurance to students while they are enrolled in the training program.

131.5(4) *Staff.*

a. A training program medical director shall be a physician licensed under Iowa Code chapter 148.

b. A training program director who is an appropriate health care professional shall be appointed. This individual shall be a full-time educator or a practitioner in emergency or critical care.

c. Course coordinators, outreach course coordinators, and primary instructors used by the training program shall be currently endorsed as EMS instructors.

d. The instructional staff shall be comprised of physicians, nurses, pharmacists, emergency medical care personnel, or other health care professionals who have appropriate education and experience in emergency and critical care.

e. Preceptors shall be assigned in each of the clinical units in which emergency medical care students are obtaining clinical experience and field experience. The preceptors shall supervise student activities to ensure the quality and relevance of the experience. Student activity records shall be kept and reviewed by the immediate supervisor(s) and by the program director and course coordinator.

f. If a training program's medical director resigns, the training program director shall report this to the department and provide a curriculum vitae for the medical director's replacement. A new course shall not be started until a qualified medical director has been appointed.

g. A training program shall maintain records pertaining to each instructor used which include, as a minimum, the instructor's qualifications.

h. A training program is responsible for ensuring that each instructor is experienced in the area being taught and adheres to the education standards.

i. The training program shall ensure that each practical examination evaluator and mock patient is familiar with the NREMT practical examination requirements and procedures. Practical examination evaluators shall attend a workshop sponsored by the department and have the evaluator endorsement.

131.5(5) *Advisory committee.* There shall be an advisory committee which includes training program representatives and representatives from other groups such as affiliated medical facilities, local medical establishments, and ambulance, rescue and first response service programs.

131.5(6) *Student records.* A training program shall maintain an individual record for each student. Training program policy and department requirements will determine contents. These requirements include, but are not limited to:

a. Application;

b. Current certifications and endorsements;

c. Student record or transcript of hours and performance (including examinations) in classroom, clinical, and field experience settings.

131.5(7) *Selection of students.* There may be a selection committee to select students. The selection committee shall use, as a minimum, the prerequisites outlined in rule 641—131.2(147A).

131.5(8) *Students.*

a. A student may perform any procedures and skills for which the student has received training if the student is under the direct supervision of a physician or physician designee or under the remote supervision of a physician or physician designee with direct field supervision by an appropriately certified emergency medical care provider.

b. A student shall not be substituted for the regular personnel of any affiliated medical facility or service program but may be employed while enrolled in the training program.

c. A student is not eligible to continue functioning as a student of the training program in the clinical or field setting if the student is not in good standing with the training program, once the student has met the training program requirements, or once the student has been approved for certification testing.

131.5(9) *Financing and administration.*

a. There shall be sufficient funding available to the training program to ensure that each class started can be completed.

b. Tuition charged to students shall be accurately stated.

c. Advertising for training programs shall be appropriate.

d. A training program shall provide to each student, no later than the first session of the course, a guide that outlines, as a minimum:

(1) Course objectives.

(2) Required hours for completion.

(3) Minimum acceptable scores on interim testing.

(4) Attendance requirements.

(5) Grievance procedure.

(6) Disciplinary actions that may be invoked, the grounds for such actions, and the process provided.

(7) Requirements for certification.

131.5(10) *Training program application, inspection and approval.*

a. A training program graduating students at the paramedic level after December 31, 2012, must be accredited by, or must have submitted a self-study application to, the Committee on Accreditation for the Emergency Medical Services Professions.

b. A training program seeking initial or renewal approval shall use the EMS Training Program Application provided by the department. The application shall include, as a minimum:

(1) Names of appropriate officials of the training program;

(2) Evidence of availability of clinical resources;

(3) Evidence of availability of physical facilities;

(4) Evidence of qualified faculty;

(5) Qualifications and major responsibilities of each faculty member;

(6) Policies used for selection, promotion, and graduation of trainees;

(7) Practices followed in safeguarding the health and well-being of trainees and of patients receiving emergency medical care within the scope of the training program; and

(8) Level(s) of EMS certification to be offered.

c. A new training program shall submit a needs assessment which justifies the need for the training program.

d. Applications shall be reviewed by the department in accordance with the 2005 Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions, published by the Commission on Accreditation of Allied Health Education Programs. Failure to comply with the standards may lead to disciplinary action as described in rule 641—131.8(147A).

e. The department shall perform an on-site inspection of the training program's facilities and clinical resources. The purpose of the inspection is to examine educational objectives, patient care practices, facilities and administrative practices and to prepare a written report for review and action by the department.

f. The department shall inspect each training program at least once every five years. The department without prior notification may make additional inspections at times, places and under such circumstances as it deems necessary to ensure compliance with Iowa Code chapter 147A and these rules.

g. No person shall interfere with the inspection activities of the department or its agents. Interference with or failure to allow an inspection may be cause for disciplinary action regarding training program approval.

h. Representatives of the training program may be required by the department to meet with the department at the time the application and inspection report are discussed.

i. A written report of department action and the department inspection report shall be sent to the training program.

j. Training program approval shall not exceed five years.

k. A training program shall notify the department, in writing, of any change in ownership or control within 30 days.

l. Temporary variances. If during a period of authorization there is some occurrence that temporarily causes a training program to be in noncompliance with these rules, the department may grant a temporary variance. Temporary variances to these rules (not to exceed six months in length per any approved request) may be granted by the department to a currently authorized training program. Requests for temporary variances shall apply only to the training program requesting the variance and shall apply only to those requirements and standards for which the department is responsible. To request a variance, the training program shall:

(1) Notify the department verbally (as soon as possible) of the need to request a temporary variance. The program shall submit to the department, within ten days after having given verbal notification to the department, a written explanation for the temporary variance request. The address is Iowa Department of Public Health, Bureau of EMS, Lucas State Office Building, Des Moines, Iowa 50319-0075.

(2) Cite the rule from which the variance is requested.

(3) State why compliance with the rule cannot be maintained.

(4) Explain the alternative arrangements that have been or will be made regarding the variance request.

(5) Estimate the period of time for which the variance will be needed.

m. Training program applications and on-site inspection reports are public information.

131.5(11) *Out-of-state training program application and approval.*

a. An out-of-state training program shall apply to the department for approval.

b. An out-of-state training program seeking department approval shall use the out-of-state training program application provided by the department. The application shall include, as a minimum:

(1) Verification of approval to conduct initial EMS training by the authorizing agency within the out-of-state training program's home state;

(2) Evidence of oversight provided by a physician medical director;

(3) Evidence of qualified faculty;

(4) Evidence of curriculum utilized;

(5) Evidence of written contracts between the out-of-state training program and clinical and field sites being utilized within Iowa; and

(6) Description of practices followed in safeguarding the health and well-being of trainees and of patients receiving emergency medical care within the scope of the training program.

c. An out-of-state training program shall provide the department with a roster of students who will be participating in the clinical or field experience within the state of Iowa and, for each program, the sites where the students will be participating.

d. An out-of-state training program shall not be authorized to provide initial EMS training within the state of Iowa.

e. An out-of-state training program shall be limited to utilization of clinical or field sites or both within Iowa.

f. Representatives of the out-of-state training program may be required by the department to meet with the department at the time the application is discussed.

g. An out-of-state training program approval shall not exceed five years.

h. An out-of-state training program shall notify the department, in writing, of any change in ownership, control, or approval status by the out-of-state training program's authorizing state agency within 30 days.

131.5(12) *Out-of-state students.*

a. An out-of-state student shall be registered in good standing in an approved out-of-state training program.

b. An out-of-state student may perform any procedures and skills for which the student is training provided that the procedure or skill is within the Iowa scope of practice policy of a comparable Iowa emergency medical care provider. The student must be under the direct supervision of a physician or physician designee or under the remote supervision of a physician or physician designee with direct supervision by an appropriately certified emergency medical care provider.

c. An out-of-state student shall not be substituted for personnel of any affiliated medical facility or service program but may be employed while enrolled in the training program.

d. An out-of-state student participating in the clinical or field setting within the state of Iowa shall provide documentation of liability insurance.

e. An out-of-state student is not eligible to continue functioning as a student of the approved out-of-state training program in the clinical or field setting if the student is not in good standing with the approved out-of-state training program, once the student has met the training program's requirements, or once the student has been approved for certification testing.

f. An out-of-state student shall not be eligible for Iowa EMS certification without meeting the requirements for certification through reciprocity in subrule 131.4(9).

[**ARC 9443B**, IAB 4/6/11, effective 8/1/11]

641—131.6(147A) Continuing education providers—approval, record keeping and inspection.

131.6(1) Continuing education courses for emergency medical care personnel may be approved by the department, an EMS training program or a national EMS continuing education accreditation entity.

131.6(2) A training program may conduct continuing education courses (utilizing appropriate instructors) pursuant to subrule 131.4(6).

a. Each training program shall assign a sponsor number to each appropriate continuing education course using an assignment system approved by the department.

b. Course approval shall be completed prior to the course's being offered.

c. Each training program shall maintain a participant record that includes, as a minimum:

(1) Name.

(2) Address.

(3) Certification number.

(4) Course sponsor number.

(5) Course instructor.

(6) Date of course.

(7) CEHs awarded.

d. Each training program shall submit to the department on a quarterly basis a completed Approved EMS Continuing Education Form.

131.6(3) Record keeping and record inspection.

a. To ensure compliance or to verify the validity of any training program application, the department may request additional information or inspect the records of any continuing education provider who is currently approved or who is seeking approval.

b. No person shall interfere with the inspection activities of the department or its agents. Interference with or failure to allow an inspection may be cause for disciplinary action regarding training program approval.
[**ARC 9443B**, IAB 4/6/11, effective 8/1/11]

641—131.7(147A) Complaints and investigations—denial, citation and warning, probation, suspension, or revocation of emergency medical care personnel certificates or renewal.

131.7(1) This rule is not subject to waiver or variance pursuant to 641—Chapter 178 or any other provision of law.

131.7(2) Method of discipline. The department has the authority to impose the following disciplinary sanctions against an emergency medical care provider:

a. Issue a citation and warning.

b. Impose a civil penalty not to exceed $1000.

c. Require reexamination.

d. Require additional education or training.

e. Impose a period of probation under specific conditions.

f. Prohibit permanently, until further order of the department, or for a specific period, a provider's ability to engage in specific procedures, methods, acts or activities incident to the practice of the profession.

g. Suspend a certificate until further order of the department or for a specific period.

h. Deny an application for certification.

i. Revoke a certification.

j. Impose such other sanctions as allowed by law and as may be appropriate.

131.7(3) The department may deny an application for issuance or renewal of an emergency medical care provider certificate, including endorsement, or may impose any of the disciplinary sanctions provided in subrule 131.7(2) when it finds that the applicant or certificate holder has committed any of the following acts or offenses:

a. Negligence in performing emergency medical care.

b. Failure to follow the directions of supervising physicians or their designees.

c. Rendering treatment not authorized under Iowa Code chapter 147A.

d. Fraud in procuring certification or renewal including, but not limited to:

(1) An intentional perversion of the truth in making application for a certification to practice in this state;

(2) False representations of a material fact, whether by word or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed when making application for a certification in this state; or

(3) Attempting to file or filing with the department or training program any false or forged diploma or certificate or affidavit or identification or qualification in making an application for a certification in this state.

e. Professional incompetency. Professional incompetency includes, but is not limited to:

(1) A substantial lack of knowledge or ability to discharge professional obligations within the scope of practice.

(2) A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other emergency medical care providers in the state of Iowa acting in the same or similar circumstances.

(3) A failure to exercise the degree of care which is ordinarily exercised by the average emergency medical care provider acting in the same or similar circumstances.

(4) Failure to conform to the minimal standard of acceptable and prevailing practice of certified emergency medical care providers in this state.

f. Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of the profession or engaging in unethical conduct or practice harmful or detrimental to the public. Proof

of actual injury need not be established. Acts which may constitute unethical conduct include, but are not limited to:

(1) Verbally or physically abusing a patient or coworker.

(2) Improper sexual contact with or making suggestive, lewd, lascivious or improper remarks or advances to a patient or coworker.

(3) Betrayal of a professional confidence.

(4) Engaging in a professional conflict of interest.

(5) Falsification of medical records.

g. Engaging in any conduct that subverts or attempts to subvert a department investigation.

h. Failure to comply with a subpoena issued by the department or failure to cooperate with an investigation of the department.

i. Failure to comply with the terms of a department order or the terms of a settlement agreement or consent order.

j. Failure to report another emergency medical care provider to the department for any violations listed in these rules, pursuant to Iowa Code chapter 147A.

k. Knowingly aiding, assisting or advising a person to unlawfully practice EMS.

l. Representing oneself as an emergency medical care provider when one's certification has been suspended or revoked or when one's certification is lapsed or has been placed on inactive status.

m. Permitting the use of a certification by a noncertified person for any purpose.

n. Mental or physical inability reasonably related to and adversely affecting the emergency medical care provider's ability to practice in a safe and competent manner.

o. Being adjudged mentally incompetent by a court of competent jurisdiction.

p. Sexual harassment of a patient, student, or supervisee. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

q. Habitual intoxication or addiction to drugs.

(1) The inability of an emergency medical care provider to practice with reasonable skill and safety by reason of the excessive use of alcohol on a continuing basis.

(2) The excessive use of drugs which may impair an emergency medical care provider's ability to practice with reasonable skill or safety.

(3) Obtaining, possessing, attempting to obtain or possess, or administering controlled substances without lawful authority.

r. Fraud in representation as to skill, ability or certification.

s. Willful or repeated violations of Iowa Code chapter 147A or these rules.

t. Violating a statute of this state, another state, or the United States, without regard to its designation as either a felony or misdemeanor, which relates to the provision of emergency medical care, including but not limited to a crime involving dishonesty, fraud, theft, embezzlement, controlled substances, substance abuse, assault, sexual abuse, sexual misconduct, or homicide. A copy of the record of conviction or plea of guilty is conclusive evidence of the violation.

u. Having certification to practice emergency medical care suspended or revoked or having other disciplinary action taken by a licensing or certifying authority of this state or another state, territory or country. A copy of the record or order of suspension, revocation or disciplinary action is conclusive or prima facie evidence.

v. Falsifying certification renewal reports or failure to comply with the renewal audit request.

w. Acceptance of any fee by fraud or misrepresentation.

x. Repeated failure to comply with standard precautions for preventing transmission of infectious diseases as issued by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services.

y. Violating privacy and confidentiality. An emergency medical care provider shall not disclose or be compelled to disclose patient information unless required or authorized by law.

z. Discrimination. An emergency medical care provider shall not practice, condone, or facilitate discrimination against a patient, student, or supervisee on the basis of race, ethnicity, national origin,

color, sex, sexual orientation, age, marital status, political belief, religion, mental or physical disability, diagnosis, or social or economic status.

aa. Practicing emergency medical services or using a designation of certification or otherwise holding oneself out as practicing emergency medical services at a certain level of certification when the emergency medical care provider is not certified at such level.

ab. Failure to respond within 30 days of receipt, unless otherwise specified, of communication from the department which was sent by registered or certified mail.

[**ARC 9443B**, IAB 4/6/11, effective 8/1/11]

641—131.8(147A) Complaints and investigations—denial, citation and warning, probation, suspension, or revocation of training program approval or renewal.

131.8(1) This rule is not subject to waiver or variance pursuant to 641—Chapter 178 or any other provision of law.

131.8(2) Method of discipline. The department has the authority to impose the following disciplinary sanctions against a training program:

a. Issue a citation and warning.

b. Impose a period of probation under specific conditions.

c. Prohibit permanently, until further order of the department, or for a specific period, a program's ability to engage in specific procedures, methods, acts or activities incident to the practice of the profession.

d. Suspend an authorization until further order of the department or for a specific period.

e. Deny an application for authorization.

f. Revoke an authorization.

g. Impose such other sanctions as allowed by law and as may be appropriate.

131.8(3) The department may impose any of the disciplinary sanctions provided in subrule 131.8(2) when it finds that the training program or applicant has failed to meet the applicable provisions of these rules or has committed any of the following acts or offenses:

a. Fraud in procuring approval or renewal.

b. Falsification of training or continuing education records.

c. Suspension or revocation of approval to provide emergency medical care training or other disciplinary action taken pursuant to Iowa Code chapter 147A. A certified copy of the record or order of suspension, revocation or disciplinary action is conclusive or prima facie evidence.

d. Engaging in any conduct that subverts or attempts to subvert a department investigation.

e. Failure to respond within 30 days of receipt of communication from the department which was sent by registered or certified mail.

f. Failure to comply with a subpoena issued by the department or failure to cooperate with an investigation of the department.

g. Failure to comply with the terms of a department order or the terms of a settlement agreement or consent order.

h. Submission of a false report of continuing education or failure to submit the quarterly report of continuing education.

i. Knowingly aiding, assisting or advising a person to unlawfully practice EMS.

j. Representing itself as an approved training program or continuing education provider when approval has been suspended or revoked or when approval has lapsed or has been placed on inactive status.

k. Using an unqualified individual as an instructor or evaluator.

l. Allowing verbal or physical abuse of a student or staff.

m. A training program provider or continuing education provider shall not sexually harass a patient, student, or supervisee. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

n. Betrayal of a professional confidence.

o. Engaging in a professional conflict of interest.

p. Discrimination. A training program or continuing education provider shall not practice, condone, or facilitate discrimination against a patient, student, or supervisee on the basis of race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, mental or physical disability, diagnosis, or social or economic status.

q. Failure to comply with the 2005 Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions, published by the Commission on Accreditation of Allied Health Education Programs.

[**ARC 9443B**, IAB 4/6/11, effective 8/1/11]

641—131.9(147A) Reinstatement of certification.

131.9(1) Any person whose certification to practice has been revoked or suspended may apply to the department for reinstatement in accordance with the terms and conditions of the order of revocation or suspension, unless the order of revocation provides that the certification is permanently revoked.

131.9(2) If the order of revocation or suspension did not establish terms and conditions upon which reinstatement might occur or if the certification was voluntarily surrendered, an initial application for reinstatement may not be made until one year has elapsed from the date of the order or the date of the voluntary surrender.

131.9(3) All proceedings for reinstatement shall be initiated by the respondent, who shall file with the department an application for reinstatement of the certification. Such application shall be docketed in the original case in which the certification was revoked, suspended, or relinquished. All proceedings upon the application for reinstatement shall be subject to the same rules of procedure as other cases before the department.

131.9(4) An application for reinstatement shall allege facts which, if established, will be sufficient to enable the department to determine that the basis for the revocation or suspension of the respondent's certification no longer exists and that it will be in the public interest for the certification to be reinstated. The burden of proof to establish such facts shall be on the respondent.

131.9(5) An order denying or granting reinstatement shall be based upon a decision which incorporates findings of facts and conclusions of law. The order shall be published as provided for in this chapter.

[**ARC 9443B**, IAB 4/6/11, effective 8/1/11]

641—131.10(147A) Certification denial.

131.10(1) An applicant who has been denied certification by the department may appeal the denial and request a hearing on the issues related to the licensure denial by serving a notice of appeal and request for hearing upon the department not more than 20 days following the date of mailing of the notification of certification denial to the applicant. The request for hearing shall specifically delineate the facts to be contested at hearing.

131.10(2) All hearings held pursuant to this rule shall be held pursuant to the process outlined in this chapter.

[**ARC 9443B**, IAB 4/6/11, effective 8/1/11]

641—131.11(147A) Emergency adjudicative proceedings. To the extent necessary to prevent or avoid immediate danger to the public health, safety or welfare and consistent with the Constitution and other provisions of law, the department may issue a written order in compliance with Iowa Code section 17A.18 to suspend a certificate in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the department by emergency adjudicative order.

131.11(1) Before issuing an emergency adjudicative order, the department shall consider factors including, but not limited to, the following:

a. Whether there has been a sufficient factual investigation to ensure that the department is proceeding on the basis of reliable information;

b. Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing;

c. Whether the individual required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare;

d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare; and

e. Whether the specific action contemplated by the department is necessary to avoid the immediate danger.

131.11(2) Issuance of order.

a. An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger in the department's decision to take immediate action. The order is a public record.

b. The written emergency adjudicative order shall be immediately delivered to the individual who is required to comply with the order. Delivery shall be made by one or more of the following procedures:

(1) Personal delivery.

(2) Certified mail, return receipt requested, to the last address on file with the department.

(3) Fax. Fax may be used as the sole method of delivery if the individual required to comply with the order has filed a written request that agency orders be sent by fax and has provided a fax number for that purpose.

c. To the degree practicable, the department shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

d. Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the department shall make reasonable immediate efforts to contact by telephone the individual who is required to comply with the order.

e. After the issuance of an emergency adjudicative order, the department shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.

f. Issuance of a written emergency adjudicative order shall include notification of the date on which department proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further department proceedings to a later date will be granted only in compelling circumstances upon application in writing unless the individual that is required to comply with the order is the party requesting the continuance.

[**ARC 9443B**, IAB 4/6/11, effective 8/1/11]

641—131.12(147A) Complaints, investigations and appeals.

131.12(1) This rule is not subject to waiver or variance pursuant to 641—Chapter 178 or any other provision of law.

131.12(2) All complaints regarding emergency medical care personnel, training programs or continuing education providers, or those purporting to be or operating as the same, shall be reported to the department in writing. The address is Iowa Department of Public Health, Bureau of EMS, Lucas State Office Building, Des Moines, Iowa 50319-0075.

131.12(3) An emergency medical care provider who has knowledge of an emergency medical care provider or service program that has violated Iowa Code chapter 147A, 641—Chapter 132 or these rules shall report such information to the department.

131.12(4) Complaint investigations may result in the department's issuance of a notice of denial, citation and warning, probation, suspension or revocation.

131.12(5) A determination of mental incompetence by a court of competent jurisdiction automatically suspends a certificate for the duration of the certificate unless the department orders otherwise.

131.12(6) Notice of denial, issuance of a citation and warning, probation, suspension or revocation shall be affected in accordance with the requirements of Iowa Code section 17A.12. Notice to the alleged violator of denial, probation, suspension or revocation shall be served by certified mail, return receipt requested, or by personal service.

131.12(7) Any request for a hearing concerning the denial, citation and warning, probation, suspension or revocation shall be submitted by the aggrieved party in writing to the department by certified mail, return receipt requested, within 20 days of the receipt of the department's notice to take action. The address is Iowa Department of Public Health, Bureau of EMS, Lucas State Office Building, Des Moines, Iowa 50319-0075. If the request is made within the 20-day time period, the notice to take action shall be deemed to be suspended pending the hearing. Prior to or at the hearing, the department may rescind the notice upon satisfaction that the reason for the denial, citation and warning, probation, suspension or revocation has been or will be removed. If no request for a hearing is received within the 20-day time period, the department's notice of denial, citation and warning, probation, suspension or revocation shall become the department's final agency action.

131.12(8) Upon receipt of a request for hearing, the department shall forward the request within five working days to the department of inspections and appeals pursuant to the rules adopted by that agency regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information which may be provided by the aggrieved party shall also be provided to the department of inspections and appeals.

131.12(9) The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10.

131.12(10) When the administrative law judge makes a proposed decision and order, it shall be served by certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final agency action without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken as provided in subrule 131.12(11).

131.12(11) Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.

131.12(12) Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director. The record shall include the following:

a. All pleadings, motions, and rules.

b. All evidence received or considered and all other submissions by recording or transcript.

c. A statement of all matters officially noticed.

d. All questions and offers of proof, objections and rulings on them.

e. All proposed findings and exceptions.

f. The proposed decision and order of the administrative law judge.

131.12(13) The decision and order of the director becomes the department's final agency action upon receipt by the aggrieved party and shall be delivered by certified mail, return receipt requested, or by personal service.

131.12(14) It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final agency action of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

131.12(15) Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal shall be sent to the department by certified mail, return receipt requested, or by personal service. The address is Iowa Department of Public Health, Bureau of EMS, Lucas State Office Building, Des Moines, Iowa 50319-0075.

131.12(16) The party who appeals a final agency action to the district court shall pay the cost of the preparation of a transcript of the contested case hearing for the district court.

131.12(17) Final decisions of the department relating to disciplinary proceedings may be transmitted to the appropriate professional associations, the news media or employer.
[**ARC 9443B**, IAB 4/6/11, effective 8/1/11]

These rules are intended to implement Iowa Code chapter 147A.

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CHAPTER 132
EMERGENCY MEDICAL SERVICES—SERVICE PROGRAM AUTHORIZATION

[Joint Rules pursuant to 147A.4]
[Prior to 7/29/87, Health Department[470] Ch 132]

641—132.1(147A) Definitions. For the purpose of these rules, the following definitions shall apply:

"Advanced emergency medical technician" or *"AEMT"* means an individual who has successfully completed a course of study based on the United States Department of Transportation's Advanced Emergency Medical Technician Instructional Guidelines (January 2009), has passed the National Registry of Emergency Medical Technicians (NREMT) practical and cognitive examinations for the AEMT, and is currently certified by the department as an AEMT.

"Ambulance" means any privately or publicly owned ground vehicle specifically designed, modified, constructed, equipped, staffed and used regularly to transport the sick, injured or otherwise incapacitated.

"Ambulance service" means any privately or publicly owned service program which utilizes ambulances in order to provide patient transportation and emergency medical services.

"Automated defibrillator" means any external semiautomatic device that determines whether defibrillation is required.

"Automated external defibrillator" or *"AED"* means an external semiautomated device that determines whether defibrillation is required.

"CEH" means "continuing education hour" which is based upon a minimum of 50 minutes of training per hour.

"Continuous quality improvement (CQI)" means a program that is an ongoing process to monitor standards at all EMS operational levels including the structure, process, and outcomes of the patient care event.

"CPR" means training and successful course completion in cardiopulmonary resuscitation, AED and obstructed airway procedures for all age groups according to recognized national standards.

"Critical care paramedic" or *"CCP"* means a currently certified paramedic specialist or paramedic who has successfully completed a critical care course of instruction approved by the department and has received endorsement from the department as a critical care paramedic.

"Critical care transport" or *"CCT"* means specialty care patient transportation, when medically necessary for a critically ill or injured patient needing critical care paramedic skills, provided by an authorized ambulance service that is approved by the department to provide critical care transportation and staffed by one or more critical care paramedics or other health care professional in an appropriate specialty area.

"Current course completion" means written recognition given for training and successful course completion of CPR with an expiration date or a recommended renewal date that exceeds the current date.

"Deficiency" means noncompliance with Iowa Code chapter 147A or these rules.

"Department" means the Iowa department of public health.

"Director" means the director of the Iowa department of public health.

"Direct supervision" means services provided by an EMS provider in a hospital setting or other health care entity in which health care is ordinarily performed when in the personal presence of a physician or under the direction of a physician who is immediately available or under the direction of a physician assistant or registered nurse who is immediately available and is acting consistent with adopted policies and protocols of a hospital or other health care entity.

"Emergency medical care" means such medical procedures as:

1. Administration of intravenous solutions.
2. Intubation.
3. Performance of cardiac defibrillation and synchronized cardioversion.
4. Administration of emergency drugs as provided by protocol.
5. Any medical procedure authorized by 131.3(3).

"Emergency medical care provider" means an individual who has been trained to provide emergency and nonemergency medical care at the EMR, EMT, AEMT, paramedic or other certification levels recognized by the department before 2011 and who has been issued a certificate by the department.

"Emergency medical responder" or *"EMR"* means an individual who has successfully completed a course of study based on the United States Department of Transportation's Emergency Medical Responder Instructional Guidelines (January 2009), has passed the NREMT practical and cognitive examinations for the EMR, and is currently certified by the department as an EMR.

"Emergency medical services" or *"EMS"* means an integrated medical care delivery system to provide emergency and nonemergency medical care at the scene or during out-of-hospital patient transportation in an ambulance.

"Emergency medical technician" or *"EMT"* means an individual who has successfully completed a course of study based on the United States Department of Transportation's Emergency Medical Technician Instructional Guidelines (January 2009), has passed the NREMT practical and cognitive examinations for the EMT, and is currently certified by the department as an EMT.

"Emergency medical technician-basic (EMT-B)" means an individual who has successfully completed the current United States Department of Transportation's Emergency Medical Technician-Basic curriculum and department enhancements, passed the department's approved written and practical examinations, and is currently certified by the department as an EMT-B.

"Emergency medical technician-intermediate (EMT-I)" means an individual who has successfully completed an EMT-intermediate curriculum approved by the department, passed the department's approved written and practical examinations, and is currently certified by the department as an EMT-I.

"Emergency medical technician-paramedic" or *"EMT-P"* means an individual who has successfully completed the United States Department of Transportation's EMT-Intermediate (1999) or the 1985 or earlier DOT EMT-P curriculum, has passed the department's approved written and practical examinations, and is currently certified by the department as an EMT-P.

"Emergency medical transportation" means the transportation, by ambulance, of sick, injured or otherwise incapacitated persons who require emergency medical care.

"EMS advisory council" means a council appointed by the director to advise the director and develop policy recommendations concerning regulation, administration, and coordination of emergency medical services in the state.

"EMS contingency plan" means an agreement or dispatching policy between two or more ambulance service programs that addresses how and under what circumstances patient transportation will be provided in a given service area when coverage is not possible due to unforeseen circumstances.

"EMS system" is any specific arrangement of emergency medical personnel, equipment, and supplies designed to function in a coordinated fashion.

"Endorsement" means an approval granted by the department authorizing an individual to serve as an EMS-I, EMS-E or CCP.

"First responder (FR)" means an individual who has successfully completed the current United States Department of Transportation's First Responder curriculum and department enhancements, passed the department's approved written and practical examinations, and is currently certified by the department as an FR.

"First response vehicle" means any privately or publicly owned vehicle which is used solely for the transportation of emergency medical care personnel and equipment to and from the scene of a medical or nonmedical emergency.

"Hospital" means any hospital licensed under the provisions of Iowa Code chapter 135B.

"Inclusion criteria" means criteria determined by the department and adopted by reference to determine which patients are to be included in the Iowa EMS service program registry or the trauma registry.

"Intermediate" means an emergency medical technician-intermediate.

"Iowa EMS Patient Registry Data Dictionary" means reportable data elements for all ambulance service responses and definitions determined by the department and adopted by reference.

"Medical direction" means direction, advice, or orders provided by a medical director, supervising physician, or physician designee (in accordance with written parameters and protocols) to emergency medical care personnel.

"Medical director" means any physician licensed under Iowa Code chapter 148, 150, or 150A who shall be responsible for overall medical direction of the service program and who has completed a medical director workshop, sponsored by the department, within one year of assuming duties.

"Mutual aid" means an agreement, preferably in writing, between two or more services that addresses how and under what circumstances each service will respond to a request for assistance in situations that exhaust available resources.

"Nonemergency transportation" means transportation that may be provided for those persons determined to need transportation only.

"Nontransport service" means any privately or publicly owned rescue or first response service program which does not provide patient transportation (except when no ambulance is available or in a disaster situation) and utilizes only rescue or first response vehicles to provide emergency medical care at the scene of an emergency.

"Off-line medical direction" means the monitoring of EMS providers through retrospective field assessments and treatment documentation review, critiques of selected cases with the EMS personnel, and statistical review of the system.

"On-line medical direction" means immediate medical direction provided directly to service program EMS providers, in accordance with written parameters and protocols, by the medical director, supervising physician or physician designee either on-scene or by any telecommunications system.

"Paramedic" means an individual who has successfully completed a course of study based on the United States Department of Transportation's Paramedic Instructional Guidelines (January 2009), has passed the NREMT practical and cognitive examinations for the paramedic, and is currently certified by the department as a paramedic.

"Paramedic specialist (PS)" means an individual who has successfully completed the current United States Department of Transportation's EMT-Paramedic curriculum or equivalent, passed the department's approved written and practical examinations, and is currently certified by the department as a paramedic specialist.

"Patient" means any individual who is sick, injured, or otherwise incapacitated.

"Patient care report (PCR)" means a computerized or written report that documents the assessment and management of the patient by the emergency care provider in the out-of-hospital setting.

"Physician" means any individual licensed under Iowa Code chapter 148, 150, or 150A.

"Physician assistant (PA)" means an individual licensed pursuant to Iowa Code chapter 148C.

"Physician designee" means any registered nurse licensed under Iowa Code chapter 152, or any physician assistant licensed under Iowa Code chapter 148C and approved by the board of physician assistant examiners. The physician designee acts as an intermediary for a supervising physician in accordance with written policies and protocols in directing the care provided by emergency medical care providers.

"Preceptor" means an individual who has been assigned by the training program, clinical facility or service program to supervise students while the students are completing their clinical or field experience. A preceptor must be an emergency medical care provider certified at the level being supervised or higher, or must be licensed as a registered nurse, physician's assistant or physician.

"Protocols" means written directions and orders, consistent with the department's standard of care, that are to be followed by an emergency medical care provider in emergency and nonemergency situations. Protocols must be approved by the service program's medical director and address the care of both adult and pediatric patients.

"Registered nurse (RN)" means an individual licensed pursuant to Iowa Code chapter 152.

"Reportable patient data" means data elements and definitions determined by the department and adopted by reference to be reported to the Iowa EMS service program registry or the trauma registry or a trauma care facility on patients meeting the inclusion criteria.

"Rescue vehicle" means any privately or publicly owned vehicle which is specifically designed, modified, constructed, equipped, staffed and used regularly for rescue or extrication purposes at the scene of a medical or nonmedical emergency.

"Service director" means an individual who is responsible for the operation and administration of a service program.

"Service program" or *"service"* means any medical care ambulance service or nontransport service that has received authorization by the department.

"Service program area" means the geographic area of responsibility served by any given ambulance or nontransport service program.

"Student" means any individual enrolled in a training program and participating in the didactic, clinical, or field experience portions.

"Supervising physician" means any physician licensed under Iowa Code chapter 148, 150, or 150A. The supervising physician is responsible for medical direction of emergency medical care personnel when such personnel are providing emergency medical care.

"Tiered response" means a rendezvous of service programs to allow the transfer of patient care.

"Training program" means an NCA-approved Iowa college, the Iowa law enforcement academy or an Iowa hospital approved by the department to conduct emergency medical care training.

"Transport agreement" means a written agreement between two or more service programs that specifies the duties and responsibilities of the agreeing parties to ensure appropriate transportation of patients in a given service area.

[**ARC 8661B**, IAB 4/7/10, effective 5/12/10; **ARC 9357B**, IAB 2/9/11, effective 3/16/11; **ARC 0063C**, IAB 4/4/12, effective 5/9/12]

641—132.2(147A) Authority of emergency medical care provider.

132.2(1) Rescinded IAB 2/7/01, effective 3/14/01.

132.2(2) An emergency medical care provider who holds an active certification issued by the department may:

a. Render via on-line medical direction emergency and nonemergency medical care in those areas for which the emergency medical care provider is certified, as part of an authorized service program:

(1) At the scene of an emergency;

(2) During transportation to a hospital;

(3) While in the hospital emergency department;

(4) Until patient care is directly assumed by a physician or by authorized hospital personnel; and

(5) During transfer from one medical care facility to another or to a private home.

b. Function in any hospital or any other entity in which health care is ordinarily provided only when under the direct supervision of a physician when:

(1) Enrolled as a student in and approved by a training program;

(2) Fulfilling continuing education requirements;

(3) Employed by or assigned to a hospital or other entity in which health care is ordinarily provided only when under the direct supervision of a physician as a member of an authorized service program, or in an individual capacity, by rendering lifesaving services in the facility in which employed or assigned pursuant to the emergency medical care provider's certification and under direct supervision of a physician, physician assistant, or registered nurse. An emergency medical care provider shall not routinely function without the direct supervision of a physician, physician assistant, or registered nurse. However, when the physician, physician assistant, or registered nurse cannot directly assume emergency care of the patient, the emergency medical care personnel may perform, without direct supervision, emergency medical care procedures for which certified, if the life of the patient is in immediate danger and such care is required to preserve the patient's life;

(4) Employed by or assigned to a hospital or other entity in which health care is ordinarily provided only when under the direct supervision of a physician, as a member of an authorized service program, or in an individual capacity, to perform nonlifesaving procedures for which certified and designated in a written job description. Such procedures may be performed after the patient is observed by and when the emergency medical care provider is under the supervision of the physician, physician assistant, or

registered nurse, including when the registered nurse is not acting in the capacity of a physician designee, and where the procedure may be immediately abandoned without risk to the patient.

132.2(3) When emergency medical care personnel are functioning in a capacity identified in subrule 132.2(2), paragraph *"a,"* they may perform emergency and nonemergency medical care without contacting a supervising physician or physician designee if written protocols have been approved by the service program medical director which clearly identify when the protocols may be used in lieu of voice contact.

132.2(4) Scope of practice.

a. Emergency medical care providers shall provide only those services and procedures as are authorized within the scope of practice for which they are certified.

b. Scope of Practice for Iowa EMS Providers (July 2011) is incorporated and adopted by reference for EMS providers. For any differences that may occur between the adopted references and these administrative rules, the administrative rules shall prevail.

c. The department may grant a variance for changes to the Scope of Practice that have not yet been adopted by these rules. A variance to these rules may be granted by the department pursuant to 132.14(1).

d. Scope of Practice for Iowa EMS Providers is available through the Iowa Department of Public Health, Bureau of EMS, Lucas State Office Building, Des Moines, Iowa 50319-0075, or the bureau of EMS Web site (www.idph.state.ia.us/ems).

132.2(5) The department may approve other emergency medical care skills on a limited pilot project basis. Requests for a pilot project application shall be made to the department.

132.2(6) An emergency medical care provider who has knowledge of an emergency medical care provider, service program or training program that has violated Iowa Code chapter 147A or these rules shall report such information to the department within 30 days.

[**ARC 8230B**, IAB 10/7/09, effective 11/11/09; **ARC 0063C**, IAB 4/4/12, effective 5/9/12]

641—132.3(147A) Emergency medical care providers—requirements for enrollment in training programs. Rescinded IAB 2/9/00, effective 3/15/00.

641—132.4(147A) Emergency medical care providers—certification, renewal standards and procedures, and fees. Rescinded IAB 2/9/00, effective 3/15/00.

641—132.5(147A) Training programs—standards, application, inspection and approval. Rescinded IAB 2/9/00, effective 3/15/00.

641—132.6(147A) Continuing education providers—approval, record keeping and inspection. Rescinded IAB 2/9/00, effective 3/15/00.

641—132.7(147A) Service program—authorization and renewal procedures, inspections and transfer or assignment of certificates of authorization.

132.7(1) *General requirements for authorization and renewal of authorization.*

a. An ambulance or nontransport service in this state that desires to provide emergency medical care, in the out-of-hospital setting, shall apply to the department for authorization to establish a program utilizing certified emergency medical care providers for delivery of care at the scene of an emergency or nonemergency, during transportation to a hospital, during transfer from one medical care facility to another or to a private home, or while in the hospital emergency department and until care is directly assumed by a physician or by authorized hospital personnel. Application for authorization shall be made on forms provided by the department. Applicants shall complete and submit the forms to the department at least 30 days prior to the anticipated date of authorization.

b. To renew service program authorization, the service program shall continue to meet the requirements of Iowa Code chapter 147A and these rules. The renewal application shall be completed and submitted to the department at least 30 days before the current authorization expires.

c. Applications for authorization and renewal of authorization may be obtained upon request to: Iowa Department of Public Health, Bureau of Emergency Medical Services, Lucas State Office Building, Des Moines, Iowa 50319-0075, or the bureau of EMS Web site (www.idph.state.ia.us/ems).

d. The department shall approve an application when the department is satisfied that the program proposed by the application will be operated in compliance with Iowa Code chapter 147A and these administrative rules.

e. Service program authorization is valid for a period of three years from its effective date unless otherwise specified on the certificate of authorization or unless sooner suspended or revoked.

f. Service programs shall be fully operational upon the effective date and at the level specified on the certificate of authorization and shall meet all applicable requirements of Iowa Code chapter 147A and these rules. Deficiencies that are identified shall be corrected within a time frame determined by the department.

g. The certificate of authorization shall be issued to the service program based in the city named in the application. Any ambulance service or nontransport service that operates from more than one city shall apply for and, if approved, shall receive an inclusive authorization for each city of operation that is listed in the application.

h. Any service program owner in possession of a certificate of authorization as a result of transfer or assignment shall continue to meet all applicable requirements of Iowa Code chapter 147A and these rules. In addition, the new owner shall apply to the department for a new certificate of authorization within 30 days following the effective date of the transfer or assignment.

i. Service programs that acquire and maintain current status with a nationally recognized EMS service program accreditation entity that meets or exceeds Iowa requirements may be exempted from the service application/inspection process. A copy of the state service application and accreditation inspection must be filed with the department for approval.

132.7(2) *Out-of-state service programs.*

a. Service programs located in other states which wish to provide emergency medical care in Iowa must meet all requirements of Iowa Code chapter 147A and these rules and must be authorized by the department except when:

(1) Transporting patients from locations within Iowa to destinations outside of Iowa;

(2) Transporting patients from locations outside of Iowa to destinations within Iowa;

(3) Transporting patients to or from locations outside of Iowa that requires travel through Iowa;

(4) Responding to a request for mutual aid in this state; or

(5) Making an occasional EMS response to locations within Iowa and then transporting the patients to destinations within Iowa.

b. An out-of-state service program that meets any of the exception criteria established in 132.7(2) shall be authorized to provide emergency medical care by the state in which the program resides and shall provide the department with verification of current state authorization upon request.

132.7(3) *Air ambulances.* Rescinded IAB 4/7/10, effective 5/12/10.

132.7(4) *Service program inspections.*

a. The department shall inspect each service program at least once every three years. The department without prior notification may make additional inspections at times, places and under such circumstances as it deems necessary to ensure compliance with Iowa Code chapter 147A and these rules.

b. The department may request additional information from or may inspect the records of any service program which is currently authorized or which is seeking authorization to ensure continued compliance or to verify the validity of any information presented on the application for service program authorization.

c. The department may inspect the patient care records of a service program to verify compliance with Iowa Code chapter 147A and these rules.

d. No person shall interfere with the inspection activities of the department or its agents pursuant to Iowa Code section 135.36.

e. Interference with or failure to allow an inspection by the department or its agents may be cause for disciplinary action in reference to service program authorization.

132.7(5) *Temporary service program authorization.*

a. A temporary service program authorization may be issued to services that wish to operate during special events that may need emergency medical care coverage. Temporary authorization is valid for a period of 30 days unless otherwise specified on the certificate of authorization or unless sooner suspended or revoked. Temporary authorization shall apply to those requirements and standards for which the department is responsible. Applicants shall complete and submit the necessary forms to the department at least 30 days prior to the anticipated date of need.

b. The service shall meet applicable requirement of these rules, but may apply for a variance using the criteria outlined in rule 641—132.14(147A).

c. The service shall submit a justification which demonstrates the need for the temporary service program authorization.

d. The service shall submit a report, to the department, within 30 days after the expiration of the temporary authorization which includes as a minimum:

(1) Number of patients treated;

(2) Types of treatment rendered;

(3) Any operational or medical problems.

132.7(6) *Conditional service program authorization.* Rescinded IAB 2/6/02, effective 3/13/02.

[**ARC 8661B**, IAB 4/7/10, effective 5/12/10; **ARC 9357B**, IAB 2/9/11, effective 3/16/11]

641—132.8(147A) Service program levels of care and staffing standards.

132.8(1) A service program seeking ambulance authorization shall:

a. Apply for authorization at one of the following levels:

(1) EMT-B/EMT.

(2) EMT-I.

(3) AEMT.

(4) EMT-P.

(5) PS/Paramedic.

b. Maintain an adequate number of ambulances and personnel to provide 24-hour-per-day, 7-day-per-week coverage. Ambulances shall comply with paragraph 132.8(1)*"d."* The number of ambulances and personnel to be maintained shall be determined by the department, and shall be based upon, but not limited to, the following:

(1) Number of calls;

(2) Service area and population; and

(3) Availability of other services in the area.

c. Provide as a minimum, on each ambulance call, the following staff:

(1) One currently certified EMT-B or EMT.

(2) One currently licensed driver. The service shall document each driver's training in CPR (AED training not required), in emergency driving techniques and in the use of the service's communications equipment. Training in emergency driving techniques shall include:

1. A review of Iowa laws regarding emergency vehicle operations.

2. A review of the service program's driving policy for first response vehicles, ambulances, rescue vehicles or personal vehicles of an emergency medical care provider responding as a member of the service. The policy shall include, at a minimum:

- Frequency and content of driver's training requirements.
- Criteria for response with lights or sirens or both.
- Speed limits when responding with lights or sirens or both.
- Procedure of approaching intersections with lights or sirens or both.
- Notification process in the event of a motor vehicle collision involving a first response vehicle, ambulance, rescue vehicle or personal vehicle of an emergency medical care provider responding as a member of the service.

3. Behind-the-wheel driving of the service's first response vehicles, ambulances and rescue vehicles.

d. Submit an EMS contingency plan that will be put into operation when coverage pursuant to the 24/7 rule in paragraph 132.8(1)*"b"* is not possible due to unforeseen circumstances.

e. Report frequency of use of the contingency plan to the department upon request.

f. Seek approval from the department to provide nontransport coverage in addition to or in lieu of ambulance authorization.

g. Advertise or otherwise imply or hold itself out to the public as an authorized ambulance service only to the level of care maintained 24 hours per day, seven days a week.

h. Apply to the department to receive approval to provide critical care transportation based upon appropriately trained staff and approved equipment.

i. Unless otherwise established by protocol approved by the medical director, the emergency medical care provider with the highest level of certification (on the transporting service) shall attend the patient.

132.8(2) A service program seeking nontransport authorization shall:

a. Apply for authorization at one of the following levels:

(1) First responder/EMR.

(2) EMT-B/EMT.

(3) EMT-I.

(4) AEMT.

(5) EMT-P.

(6) PS/Paramedic.

b. For staffing purposes provide, as a minimum, a transport agreement.

c. Advertise or otherwise hold itself out to the public as an authorized nontransport service program only to the level of care maintained 24 hours per day, seven days a week.

d. Not be prohibited from transporting patients in an emergency situation when lack of transporting resources would cause an unnecessary delay in patient care.

132.8(3) Service program operational requirements. Ambulance and nontransport service programs shall:

a. Complete and maintain a patient care report concerning the care provided to each patient. Ambulance services shall provide, at a minimum, a PCR verbal report upon delivery of a patient to a receiving facility and shall provide a complete PCR within 24 hours to the receiving facility.

b. Utilize department protocols as the standard of care. The service program medical director may make changes to the department protocols provided the changes are within the EMS provider's scope of practice and within acceptable medical practice. A copy of the changes shall be filed with the department.

c. Ensure that personnel duties are consistent with the level of certification and the service program's level of authorization.

d. Maintain current personnel rosters and personnel files. The files shall include the names and addresses of all personnel and documentation that verifies EMS provider credentials including, but not limited to:

(1) Current provider level certification.

(2) Current course completions/certifications/endorsements as may be required by the medical director.

(3) PA and RN exception forms for appropriate personnel and verification that PA and RN personnel have completed the appropriate EMS level continuing education.

e. If requested by the department, notify the department in writing of any changes in personnel rosters.

f. Have a medical director and 24-hour-per-day, 7-day-per-week on-line medical direction available.

g. Ensure that the appropriate service program personnel respond as required in this rule and that they respond in a reasonable amount of time.

h. Notify the department in writing within seven days of any change in service director or ownership or control or of any reduction or discontinuance of operations.

i. Select a new or temporary medical director if for any reason the current medical director cannot or no longer wishes to serve in that capacity. Selection shall be made before the current medical director relinquishes the duties and responsibilities of that position.

j. Within seven days of any change of medical director, notify the department in writing of the selection of the new or temporary medical director who must have indicated in writing a willingness to serve in that capacity.

k. Not prevent a registered nurse or physician assistant from supplementing the staffing of an authorized service program provided equivalent training is documented pursuant to Iowa Code sections 147A.12 and 147A.13.

l. Not be authorized to utilize a manual defibrillator (except paramedic, paramedic specialist).

m. Implement a continuous quality improvement program that provides a policy to include as a minimum:

(1) Medical audits.

(2) Skills competency.

(3) Follow-up (loop closure/resolution).

n. Require physician assistants and registered nurses providing care pursuant to Iowa Code sections 147A.12 and 147A.13 to meet CEH requirements approved by the medical director.

o. Document an equipment maintenance program to ensure proper working condition and appropriate quantities.

p. Ensure a response to requests for assistance when dispatched by a public safety answering point within the primary service area identified in the service program's authorization application.

q. Submit reportable patient data identified in subrule 132.8(7) via electronic transfer. Data shall be submitted in a format approved by the department.

r. Submit reportable patient data identified in subrule 132.8(7) to the department for each calendar quarter. Reportable patient data shall be submitted no later than 90 days after the end of the quarter.

132.8(4) Equipment and vehicle standards. The following standards shall apply:

a. Ambulances placed into service after July 1, 2002, shall meet, as a minimum, the National Truck and Equipment Association's Ambulance Manufacture Division (AMD) performance specifications.

b. All EMS service programs shall carry equipment and supplies in quantities as determined by the medical director and appropriate to the service program's level of care and available certified EMS personnel and as established in the service program's approved protocols.

c. Pharmaceutical drugs and over-the-counter drugs may be carried and administered upon completion of training and pursuant to the service program's established protocols approved by the medical director.

d. All drugs shall be maintained in accordance with the rules of the state board of pharmacy examiners.

e. Accountability for drug exchange, distribution, storage, ownership, and security shall be subject to applicable state and federal requirements. The method of accountability shall be described in the written pharmacy agreement. A copy of the written pharmacy agreement shall be submitted to the department.

f. Each ambulance service program shall maintain a telecommunications system between the emergency medical care provider and the source of the service program's medical direction and other appropriate entities. Nontransport service programs shall maintain a telecommunications system between the emergency medical care provider and the responding ambulance service and other appropriate entities.

g. All telecommunications shall be conducted in an appropriate manner and on a frequency approved by the Federal Communications Commission and the department.

132.8(5) Preventative maintenance. Each ambulance service program shall document a preventative maintenance program to make certain that:

a. Vehicles are fully equipped and maintained in a safe operating condition. In addition:

(1) All ground ambulances shall be housed in a garage or other facility that prevents engine, equipment and supply freeze-up and windshield icing. An unobstructed exit to the street shall also be maintained;

(2) The garage or other facility shall be adequately heated or each response vehicle shall have permanently installed auxiliary heating units to sufficiently heat the engine and patient compartment; and

(3) The garage or other facility shall be maintained in a clean, safe condition free of debris or other hazards.

b. The exterior and interior of the vehicles are kept clean. The interior and equipment shall be cleaned after each use as necessary. When a patient with a communicable disease has been transported or treated, the interior and any equipment or nondisposable supplies coming in contact with the patient shall be thoroughly disinfected.

c. All equipment stored in a patient compartment is secured so that, in the event of a sudden stop or movement of the vehicle, the patient and service program personnel are not injured by moving equipment.

d. All airway, electrical and mechanical equipment is kept clean and in proper operating condition.

e. Compartments provided within the vehicles and the medical and other supplies stored therein are kept in a clean and sanitary condition.

f. All linens, airway and oxygen equipment or any other supplies or equipment coming in direct patient contact is of a single-use disposable type or cleaned, laundered or disinfected prior to reuse.

g. Freshly laundered blankets and linen or disposable linens are used on cots and pillows and are changed after each use.

h. Proper storage is provided for clean linen.

i. Soiled supplies shall be appropriately disposed of according to current biohazard practices.

132.8(6) Service program—incident and accident reports.

a. Incidents of fire or other destructive or damaging occurrences or theft of a service program ambulance, equipment, or drugs shall be reported to the department within 48 hours following the occurrence of the incident.

b. A copy of the motor vehicle accident report required under Iowa Code subsection 321.266(2), relating to the reporting of an accident resulting in personal injury, death or property damage, shall be submitted to the department within seven days following an accident involving a service program vehicle.

c. A service program must report the termination of an emergency medical care provider due to negligence, professional incompetency, unethical conduct or substance use to the department within ten days following the termination.

132.8(7) Adoption by reference. The Iowa EMS Patient Registry Data Dictionary identified in 641—paragraph 136.2(1)*"c"* is adopted and incorporated by reference for inclusion criteria and reportable patient data. For any differences which may occur between the adopted reference and this chapter, the administrative rules shall prevail.

a. The Iowa EMS Patient Registry Data Dictionary identified in 641—paragraph 136.2(1)*"c"* is available through the Iowa Department of Public Health, Bureau of Emergency Medical Services, Lucas State Office Building, Des Moines, Iowa 50319-0075, or the EMS bureau Web site (www.idph.state.ia.us/ems).

b. The department shall prepare compilations for release or dissemination on all reportable patient data entered into the EMS service program registry during the reporting period. The compilations shall include, but not be limited to, trends and patient care outcomes for local, regional, and statewide evaluations. The compilations shall be made available to all service programs submitting reportable patient data to the registry.

c. Access and release of reportable patient data and information.

(1) The data collected by and furnished to the department pursuant to this subrule are confidential records of the condition, diagnosis, care, or treatment of patients or former patients, including outpatients, pursuant to Iowa Code section 22.7. The compilations prepared for release or dissemination from the data collected are not confidential under Iowa Code section 22.7, subsection 2. However, information

which individually identifies patients shall not be disclosed, and state and federal law regarding patient confidentiality shall apply.

(2) The department may approve requests for reportable patient data for special studies and analysis provided the request has been reviewed and approved by the deputy director of the department with respect to the scientific merit and confidentiality safeguards, and the department has given administrative approval for the proposal. The confidentiality of patients and the EMS service program shall be protected.

(3) The department may require entities requesting the data to pay any or all of the reasonable costs associated with furnishing the reportable patient data.

d. To the extent possible, activities under this subrule shall be coordinated with other health data collection methods.

e. Quality assurance.

(1) For the purpose of ensuring the completeness and quality of reportable patient data, the department or authorized representative may examine all or part of the patient care report as necessary to verify or clarify all reportable patient data submitted by a service program.

(2) Review of a patient care report by the department shall be scheduled in advance with the service program and completed in a timely manner.

f. The director, pursuant to Iowa Code section 147A.4, may grant a variance from the requirements of these rules for any service program, provided that the variance is related to undue hardships in complying with this chapter.

132.8(8) The patient care report is a confidential document and shall be exempt from disclosure pursuant to Iowa Code subsection 22.7(2) and shall not be accessible to the general public. Information contained in these reports, however, may be utilized by any of the indicated distribution recipients and may appear in any document or public health record in a manner which prevents the identification of any patient or person named in these reports.

132.8(9) Implementation. The director may grant exceptions and variances from the requirements of this chapter for any ambulance or nontransport service. Exceptions or variations shall be reasonably related to undue hardships which existing services experience in complying with this chapter. Services requesting exceptions and variances shall be subject to other applicable rules adopted pursuant to Iowa Code chapter 147A.

[**ARC 8661B**, IAB 4/7/10, effective 5/12/10; **ARC 9357B**, IAB 2/9/11, effective 3/16/11; **ARC 9444B**, IAB 4/6/11, effective 5/11/11; **ARC 0063C**, IAB 4/4/12, effective 5/9/12]

641—132.9(147A) Service program—off-line medical direction.

132.9(1) The medical director shall be responsible for providing appropriate medical direction and overall supervision of the medical aspects of the service program and shall ensure that those duties and responsibilities are not relinquished before a new or temporary replacement is functioning in that capacity.

132.9(2) The medical director's duties include, but need not be limited to:

a. Developing, approving and updating protocols to be used by service program personnel that meet or exceed the minimum standard protocols developed by the department.

b. Developing and maintaining liaisons between the service, other physicians, physician designees, hospitals, and the medical community served by the service program.

c. Monitoring and evaluating the activities of the service program and individual personnel performance, including establishment of measurable outcomes that reflect the goals and standards of the EMS system.

d. Assessing the continuing education needs of the service and individual service program personnel and assisting them in the planning of appropriate continuing education programs.

e. Being available for individual evaluation and consultation to service program personnel.

f. Performing or appointing a designee to complete the medical audits required in subrule 132.9(4).

g. Developing and approving an applicable continuous quality improvement policy demonstrating type and frequency of review, including an action plan and follow-up.

h. Informing the medical community of the emergency medical care being provided according to approved protocols in the service program area.

i. Helping to resolve service operational problems.

j. Approving or removing an individual from service program participation.

132.9(3) Supervising physicians, physician designees, or other appointees as defined in the continuous quality improvement policy referenced in 132.9(2)*"g"* may assist the medical director by:

a. Providing medical direction.

b. Reviewing the emergency medical care provided.

c. Reviewing and updating protocols.

d. Providing and assessing continuing education needs for service program personnel.

e. Helping to resolve operational problems.

132.9(4) The medical director or other qualified designees shall randomly audit (at least quarterly) documentation of calls where emergency medical care was provided. The medical director shall randomly review audits performed by the qualified appointee. The audit shall be in writing and shall include, but need not be limited to:

a. Reviewing the patient care provided by service program personnel and remedying any deficiencies or potential deficiencies that may be identified regarding medical knowledge or skill performance.

b. Response time and time spent at the scene.

c. Overall EMS system response to ensure that the patient's needs were matched to available resources including, but not limited to, mutual aid and tiered response.

d. Completeness of documentation.

132.9(5) Rescinded IAB 2/6/02, effective 3/13/02.

132.9(6) On-line medical direction when provided through a hospital.

a. The medical director shall designate in writing at least one hospital which has established a written on-line medical direction agreement with the department. It shall be the medical director's responsibility to notify the department in writing of changes regarding this designation.

b. Hospitals signing an on-line medical direction agreement shall:

(1) Ensure that the supervising physicians or physician designees will be available to provide on-line medical direction via telecommunications on a 24-hour-per-day basis.

(2) Identify the service programs for which on-line medical direction will be provided.

(3) Establish written protocols for use by supervising physicians and physician designees who provide on-line medical direction.

(4) Administer a quality assurance program to review orders given. The program shall include a mechanism for the hospital and service program medical directors to discuss and resolve any identified problems.

c. A hospital which has a written medical direction agreement with the department may provide medical direction for any or all service program authorization levels and may also agree to provide backup on-line medical direction for any other service program when that service program is unable to contact its primary source of on-line medical direction.

d. Only supervising physicians or physician designees shall provide on-line medical direction. A physician assistant, registered nurse or emergency medical care provider (of equal or higher level) may relay orders to emergency medical care personnel, without modification, from a supervising physician. A physician designee may not deviate from approved protocols.

e. The hospital shall provide, upon request to the department, a list of supervising physicians and physician designees providing on-line medical direction.

f. Rescinded IAB 2/6/02, effective 3/13/02.

g. The department may verify a hospital's communications system to ensure compliance with the on-line medical direction agreement.

h. A supervising physician or physician designee who gives orders (directly or via communications equipment from some other point) to an emergency medical care provider is not subject

to criminal liability by reason of having issued the orders and is not liable for civil damages for acts or omissions relating to the issuance of the orders unless the acts or omissions constitute recklessness.

i. Nothing in these rules requires or obligates a hospital, supervising physician or physician designee to approve requests for orders received from emergency medical care personnel.

NOTE: Hospitals in other states may participate provided the applicable requirements of this subrule are met.

[**ARC 0063C**, IAB 4/4/12, effective 5/9/12]

641—132.10(147A) Complaints and investigations—denial, citation and warning, probation, suspension or revocation of service program authorization or renewal.

132.10(1) All complaints regarding the operation of authorized emergency medical care service programs, or those purporting to be or operating as the same, shall be reported to the department. The address is: Iowa Department of Public Health, Bureau of Emergency Medical Services, Lucas State Office Building, Des Moines, Iowa 50319-0075.

132.10(2) Complaints and the investigative process will be treated as confidential in accordance with Iowa Code section 22.7.

132.10(3) Service program authorization may be denied, issued a civil penalty not to exceed $1000, issued a citation and warning, placed on probation, suspended, revoked, or otherwise disciplined by the department in accordance with Iowa Code subsection 147A.5(3) for any of the following reasons:

a. Knowingly allowing the falsifying of a patient care report (PCR).

b. Failure to submit required reports and documents.

c. Delegating professional responsibility to a person when the service program knows that the person is not qualified by training, education, experience or certification to perform the required duties.

d. Practicing, condoning, or facilitating discrimination against a patient, student or employee based on race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, mental or physical disability diagnosis, or social or economic status.

e. Knowingly allowing sexual harassment of a patient, student or employee. Sexual harassment includes sexual advances, sexual solicitations, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

f. Failure or repeated failure of the applicant or alleged violator to meet the requirements or standards established pursuant to Iowa Code chapter 147A or the rules adopted pursuant to that chapter.

g. Obtaining or attempting to obtain or renew or retain service program authorization by fraudulent means or misrepresentation or by submitting false information.

h. Engaging in conduct detrimental to the well-being or safety of the patients receiving or who may be receiving emergency medical care.

i. Failure to correct a deficiency within the time frame required by the department.

132.10(4) The department shall notify the applicant of the granting or denial of authorization or renewal, or shall notify the alleged violator of action to issue a citation and warning, place on probation or suspend or revoke authorization or renewal pursuant to Iowa Code sections 17A.12 and 17A.18. Notice of issuance of a denial, citation and warning, probation, suspension or revocation shall be served by restricted certified mail, return receipt requested, or by personal service.

132.10(5) Any requests for appeal concerning the denial, citation and warning, probation, suspension or revocation of service program authorization or renewal shall be submitted by the aggrieved party in writing to the department by certified mail, return receipt requested, within 20 days of the receipt of the department's notice. The address is: Iowa Department of Public Health, Bureau of Emergency Medical Services, Lucas State Office Building, Des Moines, Iowa 50319-0075. If such a request is made within the 20-day time period, the notice shall be deemed to be suspended. Prior to or at the hearing, the department may rescind the notice upon satisfaction that the reason for the denial, citation and warning, probation, suspension or revocation has been or will be removed. After the hearing, or upon default of the applicant or alleged violator, the administrative law judge shall affirm, modify or set aside the denial, citation and warning, probation, suspension or revocation. If no request

for appeal is received within the 20-day time period, the department's notice of denial, probation, suspension or revocation shall become the department's final agency action.

132.10(6) Upon receipt of an appeal that meets contested case status, the appeal shall be forwarded within five working days to the department of inspections and appeals pursuant to the rules adopted by that agency regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information which may be provided by the aggrieved party shall also be provided to the department of inspections and appeals.

132.10(7) The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10.

132.10(8) When the administrative law judge makes a proposed decision and order, it shall be served by restricted certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final agency action without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken as provided in subrule 132.10(9).

132.10(9) Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.

132.10(10) Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director. The record shall include the following:

a. All pleadings, motions, and rules.

b. All evidence received or considered and all other submissions by recording or transcript.

c. A statement of all matters officially noticed.

d. All questions and offers of proof, objections, and rulings thereon.

e. All proposed findings and exceptions.

f. The proposed decision and order of the administrative law judge.

132.10(11) The decision and order of the director becomes the department's final agency action upon receipt by the aggrieved party and shall be delivered by restricted certified mail, return receipt requested, or by personal service.

132.10(12) It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final agency action of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

132.10(13) Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal shall be sent to the department by certified mail, return receipt requested, or by personal service. The address is: Bureau of Emergency Medical Services, Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

132.10(14) The party who appeals a final agency action to the district court shall pay the cost of the preparation of a transcript of the contested case hearing for the district court.

132.10(15) Final decisions of the department relating to disciplinary proceedings may be transmitted to the appropriate professional associations, the news media or employer.

132.10(16) This rule is not subject to waiver or variance pursuant to 641—Chapter 178 or any other provision of law.

132.10(17) Emergency adjudicative proceedings.

a. Necessary emergency action. To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the Constitution and other provisions of law, the department may issue a written order in compliance with Iowa Code section 17A.18 to suspend a certificate in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the department by emergency adjudicative order.

b. Before issuing an emergency adjudicative order, the department shall consider factors including, but not limited to, the following:

(1) Whether there has been a sufficient factual investigation to ensure that the department is proceeding on the basis of reliable information;

(2) Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing;

(3) Whether the program required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare;

(4) Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare; and

(5) Whether the specific action contemplated by the department is necessary to avoid the immediate danger.

c. Issuance of order.

(1) An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger in the department's decision to take immediate action. The order is a public record.

(2) The written emergency adjudicative order shall be immediately delivered to the service program that is required to comply with the order by utilizing one or more of the following procedures:

1. Personal delivery.
2. Certified mail, return receipt requested, to the last address on file with the department.
3. Fax. Fax may be used as the sole method of delivery if the service program required to comply with the order has filed a written request that agency orders be sent by fax and has provided a fax number for that purpose.

(3) To the degree practicable, the department shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

(4) Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the department shall make reasonable immediate efforts to contact by telephone the service program that is required to comply with the order.

(5) After the issuance of an emergency adjudicative order, the department shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.

(6) Issuance of a written emergency adjudicative order shall include notification of the date on which department proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further department proceedings to a later date will be granted only in compelling circumstances upon application in writing unless the service program that is required to comply with the order is the party requesting the continuance.

[**ARC 8661B**, IAB 4/7/10, effective 5/12/10]

641—132.11(147A) Complaints and investigations—denial, citation and warning, probation, suspension, or revocation of emergency medical care personnel certificates or renewal. Rescinded IAB 2/9/00, effective 3/15/00.

641—132.12(147A) Complaints and investigations—denial, citation and warning, probation, suspension, or revocation of training program or continuing education provider approval or renewal. Rescinded IAB 2/9/00, effective 3/15/00.

641—132.13(147A) Complaints, investigations and appeals. Rescinded IAB 2/9/00, effective 3/15/00.

641—132.14(147A) Temporary variances.

132.14(1) If during a period of authorization there is some occurrence that temporarily causes a service program to be in noncompliance with these rules, the department may grant a temporary variance. Temporary variances to these rules (not to exceed six months in length per any approved request) may be

granted by the department to a currently authorized service program. Requests for temporary variances shall apply only to the service program requesting the variance and shall apply only to those requirements and standards for which the department is responsible.

132.14(2) To request a variance, the service program shall:

a. Notify the department verbally (as soon as possible) of the need to request a temporary variance. Submit to the department, within ten days after having given verbal notification to the department, a written explanation for the temporary variance request. The address and telephone number are Iowa Department of Public Health, Bureau of Emergency Medical Services, Lucas State Office Building, Des Moines, Iowa 50319-0075; (515)725-0326.

b. Cite the rule from which the variance is requested.

c. State why compliance with the rule cannot be maintained.

d. Explain the alternative arrangements that have been or will be made regarding the variance request.

e. Estimate the period of time for which the variance will be needed.

f. Rescinded IAB 2/2/05, effective 3/9/05.

132.14(3) Upon notification of a request for variance, the department shall take into consideration, but shall not be limited to:

a. Examining the rule from which the temporary variance is requested to determine if the request is appropriate and reasonable.

b. Evaluating the alternative arrangements that have been or will be made regarding the variance request.

c. Examining the effect of the requested variance upon the level of care provided to the general populace served.

d. Requesting additional information if necessary.

132.14(4) Preliminary approval or denial shall be provided verbally within 24 hours. Final approval or denial shall be issued in writing within ten days after having received the written explanation for the temporary variance request and shall include the reason for approval or denial. If approval is granted, the effective date and the duration of the temporary variance shall be clearly stated.

132.14(5) Rescinded, effective July 10, 1987.

132.14(6) Any request for appeal concerning the denial of a request for temporary variance shall be in accordance with the procedures outlined in rule 641—132.10(147A).

132.14(7) Rescinded IAB 2/3/93, effective 3/10/93.

641—132.15(147A) Transport options for fully authorized EMT-P, PS, and paramedic service programs.

132.15(1) Upon responding to an emergency call, ambulance or nontransport EMT-P, PS, and paramedic level services may make a determination at the scene as to whether emergency medical transportation or nonemergency transportation is needed. The determination shall be made by an EMT-P, paramedic or paramedic specialist and shall be based upon the nonemergency transportation protocol approved by the service program's medical director. When applying this protocol, the following criteria, as a minimum, shall be used to determine the appropriate transport option:

a. Primary assessment,

b. Focused history and physical examination,

c. Chief complaint,

d. Name, address and age, and

e. Nature of the call for assistance.

Emergency medical transportation shall be provided whenever any of the above criteria indicate that treatment should be initiated.

132.15(2) If treatment is not indicated, the service program may make arrangements for nonemergency transportation. If arrangements are made, the service program shall remain at the scene

until nonemergency transportation arrives. During the wait for nonemergency transportation, however, the ambulance or nontransport service may respond to an emergency.
[**ARC 0063C**, IAB 4/4/12, effective 5/9/12]

641—132.16(147A) Public access defibrillation. Rescinded IAB 2/2/05, effective 3/9/05.

These rules are intended to implement Iowa Code chapter 147A.

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[1] See IAB, Inspections and Appeals Department.

[2] Rescission of paragraph 132.14(2)*"f"* inadvertently omitted from 2/2/05 Supplement.

CHAPTER 37
IOWA PRESCRIPTION MONITORING PROGRAM

657—37.1(124) Purpose. These rules establish a prescription monitoring program that compiles a central database of reportable prescriptions dispensed to patients in Iowa. An authorized health care practitioner may, but is not required to, access prescription monitoring program (PMP) information regarding the practitioner's patient to assist in determining appropriate treatment options and to improve the quality of patient care. The PMP is intended to provide a health care practitioner with a resource for information regarding a patient's use of controlled substances. This database will assist the practitioner in identifying any potential diversion, misuse, or abuse of controlled substances without impeding the appropriate medical use of controlled substances.
[**ARC 7903B**, IAB 7/1/09, effective 8/5/09]

657—37.2(124) Definitions. As used in this chapter:

"Board" means the Iowa board of pharmacy.

"Controlled substance" means a drug, substance, or immediate precursor in Schedules I through V set forth in Iowa Code chapter 124, division II.

"Council" means the PMP advisory council established pursuant to Iowa Code section 124.555 to provide oversight and to co-manage PMP activities with the board.

"Database information" or *"PMP information"* means information submitted to and maintained by the PMP database.

"DEA number" means the registration number issued to an individual or pharmacy by the U.S. Department of Justice, Drug Enforcement Administration authorizing the individual or pharmacy to engage in the prescribing, dispensing, distributing, or procuring of a controlled substance.

"Dispenser" means a person who delivers to the ultimate user a substance required to be reported to the PMP database. "Dispenser" does not include a person exempt from reporting pursuant to subrule 37.3(1).

"Health care professional" means a person who, by education, training, certification, or licensure, is qualified to provide and is engaged in providing health care to patients. "Health care professional" does not include clerical or administrative staff. "Health care professional," other than a licensed prescriber or pharmacist, may include, but is not limited to, a certified pharmacy technician or a technician trainee, a nurse, or a medical assistant or supervised trainee such as a pharmacist-intern or student, a medical student, or a nursing student.

"National drug code" or *"NDC number"* means the universal product identifier used in the United States to identify a specific human drug product.

"Patient" means the person or animal that is the ultimate user of a drug for whom a prescription is issued or for whom a drug is dispensed.

"Patient's agent" means a person legally authorized to make health care decisions or gain access to health care records on behalf of the patient for purposes of directing the patient's care.

"Patients rights committee" or *"committee"* means the physician and pharmacist members of the council responsible for monitoring and ensuring protection and preservation of patients' rights as provided in Iowa Code section 124.555(3)*"e."*

"PMP administrator" means the board staff person or persons designated to manage the PMP under the direction and oversight of the board and the council.

"Practitioner" means a prescriber or a pharmacist.

"Practitioner's agent" means a health care professional who is employed by or under the direct supervision of a health care practitioner and who is authorized by the practitioner to access PMP information as provided in subrule 37.4(1).

"Prescriber" means a licensed health care professional with the authority to prescribe prescription drugs including controlled substances.

"Prescription monitoring program" or *"PMP"* means the program established pursuant to these rules for the collection and maintenance of PMP information and for the provision of PMP information to authorized individuals, including health care providers, for use in treatment of their patients.

"Prescription monitoring program database" or *"PMP database"* means a centralized database of reportable controlled substance prescriptions dispensed to patients and includes data access logs, security tracking information, and records of each individual who requests PMP information.

"Reportable prescription" means the record of a Schedule II, III, or IV controlled substance dispensed by a pharmacy to a patient pursuant to a prescriber-authorized prescription. "Reportable prescription" does not include those records excluded in subrule 37.3(1).

"Schedule II, III, and IV controlled substances" means those substances that are identified and listed as Schedule II, III, or IV substances in Iowa Code sections 124.205 through 124.210 or in the federal Controlled Substances Act (21 U.S.C. Section 812).

[**ARC 7903B**, IAB 7/1/09, effective 8/5/09; **ARC 0056C**, IAB 4/4/12, effective 7/1/12]

657—37.3(124) Requirements for the PMP. Each dispenser, unless identified as exempt from reporting pursuant to subrule 37.3(1), shall submit to the PMP administrator a record of each reportable prescription dispensed during a reporting period.

37.3(1) *Exemptions.* The dispensing of a controlled substance as described in this subrule shall not be considered a reportable prescription. A dispenser engaged in the distribution of controlled substances solely pursuant to one or more of the practices identified in paragraphs *"a"* or *"b"* of this subrule shall so notify the PMP administrator and shall be exempt from reporting to the PMP.

a. A licensed hospital pharmacy shall not be required to report the dispensing of a controlled substance for the purposes of inpatient hospital care, the dispensing of a prescription for a starter supply of a controlled substance at the time of a patient's discharge from such a facility, or the dispensing of a prescription for a controlled substance in a quantity adequate to treat the patient for a maximum of 72 hours.

b. A licensed pharmacy shall not be required to report the dispensing of a controlled substance for a patient residing in a long-term care facility or for a patient residing in an inpatient hospice facility.

c. A prescriber or other authorized person who administers or dispenses a controlled substance, including samples of a controlled substance, for the purposes of outpatient care shall not be required to report such administration or dispensing. This exception shall not apply to a pharmacist who administers a controlled substance, as directed by the prescriber, pursuant to a prescription.

d. A wholesale distributor of a controlled substance shall not be required to report the wholesale distribution of such a substance.

37.3(2) *Data elements.* The information submitted for each prescription shall include, at a minimum, the following items:

a. Dispenser DEA number.
b. Date the prescription is filled.
c. Prescription number.
d. Indication as to whether the prescription is new or a refill.
e. NDC number for the drug dispensed.
f. Quantity of the drug dispensed.
g. Number of days of drug therapy provided by the drug as dispensed.
h. Patient name.
i. Patient address including street address, city, state, and ZIP code.
j. Patient date of birth.
k. Patient gender.
l. Prescriber DEA number.
m. Date the prescription was issued by the prescriber.
n. Method of payment as either third-party payer or patient cash payment.

37.3(3) *Reporting periods.* A record of each reportable prescription dispensed shall be submitted by each dispenser pursuant to the following schedule. Records may be submitted with greater frequency than required by this schedule. This schedule defines minimum report frequency.

a. Records of reportable prescriptions dispensed between the first and the fifteenth day of a month shall be submitted no later than the twenty-fifth day of the month.

b. Records of reportable prescriptions dispensed between the sixteenth and the last day of a month shall be submitted no later than the tenth day of the following month.

37.3(4) *Transmission methods.* Prescription information shall be transmitted using one of the following methods:

a. Data upload to a reporting Web site via a secure Internet connection. The PMP administrator will provide dispensers with initial secure login and password information. Dispensers will be required to register on the reporting Web site prior to initial data upload.

b. Electronic media including CD-ROM, DVD, or diskette, accompanied by a transmittal form identifying the dispenser submitting the electronic media, the number of prescription records included on the media, and the individual submitting the media.

c. If a dispenser does not have an automated record-keeping system capable of producing an electronic report as provided in this rule, the dispenser may submit prescription information on the industry standard universal claim form. The dispenser may complete and submit the claim form on the reporting Web site or, if the dispenser does not have Internet access, the completed paper claim form may be submitted.

d. Chain pharmacies and pharmacies under shared ownership may submit combined data transmissions on behalf of all facilities by utilizing the secure FTP procedure.

37.3(5) *Zero reports.* If a dispenser has not been identified as exempt from reporting to the PMP and the dispenser did not dispense any reportable prescriptions during a reporting period, the dispenser shall submit a zero report via the established reporting Web site. If such a dispenser does not have Internet access, the dispenser shall notify the PMP administrator via mail or facsimile transmission that the dispenser did not dispense any reportable prescriptions during the reporting period. The schedule identified in subrule 37.3(3) shall determine timely submission of zero reports.

[**ARC 7903B**, IAB 7/1/09, effective 8/5/09]

657—37.4(124) Access to database information. All information contained in the PMP database, including prescription information submitted for inclusion in the PMP database and records of requests for PMP information, shall be privileged and strictly confidential and not subject to public or open records laws. The board, council, and PMP administrator shall maintain procedures to ensure the privacy and confidentiality of patients, prescribers, dispensers, practitioners, practitioners' agents, and patient information collected, recorded, transmitted, and maintained in the PMP database and to ensure that program information is not disclosed to persons except as provided in this rule.

37.4(1) *Prescribers and pharmacists.* A health care practitioner authorized to prescribe or dispense controlled substances may obtain PMP information regarding the practitioner's patient, or a patient seeking treatment from the practitioner, for the purpose of providing patient health care. A practitioner may authorize no more than three health care professionals to act as the practitioner's agents for the purpose of requesting PMP information regarding a practitioner's patients.

a. Prior to being granted access to PMP information, a practitioner or a practitioner's agent shall submit an individual request for registration and program access. A practitioner or a practitioner's agent with Internet access may register via a secure Web site established by the board for that purpose. A practitioner without Internet access shall submit a written registration request on a form provided by the PMP administrator. A practitioner without Internet access shall not authorize a practitioner's agent to register for or to access PMP information on behalf of the practitioner. The PMP administrator shall take reasonable steps to verify the identity of a practitioner or practitioner's agent and to verify a practitioner's credentials prior to providing a practitioner or practitioner's agent with a secure login and initial password. Each practitioner or practitioner's agent registered to access PMP information shall securely maintain and use the login and password assigned to the individual practitioner or practitioner's

agent. Except in an emergency when the patient would be placed in greater jeopardy by restricting PMP information access to the practitioner or practitioner's agent, a registered practitioner shall not share the practitioner's secure login and password information and shall not delegate PMP information access to another health care practitioner or to an unregistered agent. A registered practitioner's agent shall not delegate PMP information access to another individual.

b. A practitioner or practitioner's agent with Internet access may submit a request for PMP information via a secure Web site established by the board for that purpose. The requested information shall be provided to the requesting practitioner or practitioner's agent in a format established by the board and shall be delivered via the secure Web site.

c. A practitioner without Internet access may submit to the PMP administrator a written request for PMP information via mail or facsimile transmission. The written request shall be in a format established by the board and shall be signed by the requesting practitioner. Prior to processing a written request for PMP information, the PMP administrator shall take reasonable steps to verify the request, which may include but not be limited to a telephone call to the practitioner at a telephone number known to be the number for the practitioner's practice.

d. A practitioner or practitioner's agent who requests and receives PMP information consistent with the requirements and intent of these rules may provide that information to another practitioner who is involved in the care of the patient who is the subject of the information. Information from the PMP database remains privileged and strictly confidential. Such disclosures among practitioners shall be consistent with these rules and federal and state laws regarding the confidentiality of patient information. The information shall be used for medical or pharmaceutical care purposes.

37.4(2) *Regulatory agencies and boards.* Professional licensing boards and regulatory agencies that supervise or regulate a health care practitioner or that provide payment for health care services shall be able to access information from the PMP database only pursuant to an order, subpoena, or other means of legal compulsion relating to a specific investigation of a specific individual and supported by a determination of probable cause.

a. A director of a licensing board with jurisdiction over a practitioner, or the director's designee, who seeks access to PMP information for an investigation shall submit to the PMP administrator in a format established by the board a written request via mail, facsimile, or personal delivery. The request shall be signed by the director or the director's designee and shall be accompanied by an order, subpoena, or other form of legal compulsion establishing that the request is supported by a determination of probable cause.

b. A director of a regulatory agency with jurisdiction over a practitioner or with jurisdiction over a person receiving health care services pursuant to one or more programs provided by the agency, or the director's designee, who seeks access to PMP information for an investigation shall submit to the PMP administrator in a format established by the board a written request via mail, facsimile, or personal delivery. The request shall be signed by the director or the director's designee and shall be accompanied by an order, subpoena, or other form of legal compulsion establishing that the request is supported by a determination of probable cause.

37.4(3) *Law enforcement agencies.* Local, state, and federal law enforcement or prosecutorial officials engaged in the administration, investigation, or enforcement of any state or federal law relating to controlled substances shall be able to access information from the PMP database by order, subpoena, or other means of legal compulsion relating to a specific investigation of a specific individual and supported by a determination of probable cause. A law enforcement officer shall submit to the PMP administrator in a format established by the board a written request via mail, facsimile, or personal delivery. The request shall be signed by the requesting officer or the officer's superior. The request shall be accompanied by an order, subpoena, or warrant issued by a court or legal authority that requires a determination of probable cause and shall be processed by the PMP administrator. A report identifying PMP information relating to the specific individual identified by the order, subpoena, or warrant may be delivered to the law enforcement officer via mail or alternate secure delivery.

37.4(4) *Patients.* A patient or the patient's agent may request and receive PMP information regarding prescriptions reported to have been dispensed to the patient.

a. A patient may submit a signed, written request for records of the patient's prescriptions dispensed during a specified period of time. The request shall identify the patient by name, including any aliases used by the patient, and shall include the patient's date of birth and gender. The request shall also include any address where the patient resided during the time period of the request and the patient's current address and daytime telephone number. A patient may personally deliver the request to the PMP administrator or authorized staff member at the offices of the board located at 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688. The patient will be required to present current government-issued photo identification at the time of delivery of the request. A copy of the patient's identification shall be maintained in the records of the PMP.

b. A patient who is unable to personally deliver the request to the board offices may submit a request via mail or commercial delivery service. The request shall comply with all provisions of paragraph *"a"* above, and the signature of the requesting patient shall be witnessed and the patient's identity shall be attested to by a currently registered notary public. In addition to the notary's signature and assurance of the patient's identity, the notary shall certify a copy of the patient's government-issued photo identification and that certified copy shall be submitted with the written request. The request shall be submitted to the Iowa Board of Pharmacy at the address identified in paragraph *"a."*

c. In the case of a patient whose health care decisions have been legally transferred to the patient's agent, the patient's agent may submit a request on behalf of the patient pursuant to the appropriate procedure in paragraph *"a"* or *"b."* In addition to the patient's information, the patient's agent shall be identified by name, current address, and telephone number. In lieu of the patient's signature and identification, the patient's agent shall sign the request and the government-issued photo identification shall identify the patient's agent. The patient's agent shall include a certified copy of the legal document that transferred control over decisions regarding the patient's health care to the patient's agent.

37.4(5) *Court orders and subpoenas.* The PMP administrator shall provide PMP information in response to court orders and county attorney or other subpoenas issued by a court upon a determination of probable cause.

37.4(6) *Statistical data.* The PMP administrator, following review and approval by the patients rights committee, may provide summary, statistical, or aggregate data to public or private entities for statistical, research, or educational purposes. Prior to the release of any such data, the PMP administrator shall remove any information that could be used to identify an individual patient, prescriber, dispenser, practitioner, or other person who is the subject of the PMP information or data.

37.4(7) *PMP administrator access.* Other than technical, error, and administrative function reports and information needed by PMP support staff to determine that records are received and maintained in good order or to review or resolve issues of reported or suspected erroneous data as provided in rule 657—37.7(124), any other reports concerning the information received from dispensers shall only be prepared at the direction of the board, the council, or the PMP administrator. The board and the council may compile statistical reports from PMP information for use in determining the advisability of continuing the PMP and for use in preparing required reports to the governor and the legislature. The reports shall not include information that would identify any patient, prescriber, dispenser, practitioner, practitioner's agent, or other person who is the subject of the PMP information or data.

[**ARC 7903B**, IAB 7/1/09, effective 8/5/09; **ARC 0056C**, IAB 4/4/12, effective 7/1/12]

657—37.5(124) Fees. The board may charge a fee and recover costs incurred for the provision of PMP information, including statistical data, except that no fees or costs shall be assessed to a dispenser for reporting to the PMP or to a practitioner for querying the PMP regarding a practitioner's patient. Any fees or costs assessed by the board shall be considered repayment receipts as defined in Iowa Code section 8.2.

[**ARC 7903B**, IAB 7/1/09, effective 8/5/09]

657—37.6(124) PMP information retained. All dispenser records of prescriptions reported to the PMP shall be retained by the PMP for a period of four years following the date of the record. All records of access to or query of PMP information shall be retained by the PMP for a period of four years following the date of the record. At least semiannually, all PMP information identified as exceeding that four-year

period shall be deleted from the PMP and discarded in a manner to maintain the confidentiality of the PMP information and data. Statistical data and reports from which all personally identifiable information has been removed or which do not contain personally identifiable information as provided in subrules 37.4(6) and 37.4(7) may be retained by the PMP for historical purposes.
[**ARC 7903B**, IAB 7/1/09, effective 8/5/09]

657—37.7(124) Information errors. Any person who believes that PMP information about that person is false or in error shall submit a written statement to the PMP administrator. The statement shall identify the information the person believes to be false or in error and the reason the individual believes the information to be false or in error. The PMP administrator may examine the information identified in the statement and may request the assistance of the board's compliance staff to determine whether or not the PMP information is accurate. Prior to initiating any action to correct, delete, or amend any PMP information, the PMP administrator shall submit the statement and the resulting report to the patients rights committee for review and approval of the recommended action. If correction, deletion, or amendment of any PMP information is authorized, that action shall be accomplished by the PMP administrator within 72 hours of the committee's decision. The PMP administrator shall respond, in writing, to the person who submitted the statement charging that the PMP information was false or in error. The response shall identify the action approved by the committee.
[**ARC 7903B**, IAB 7/1/09, effective 8/5/09]

657—37.8(124) Dispenser and practitioner records. Nothing in these rules shall apply to records created or maintained in the regular course of business of a pharmacy or health care practitioner. All information, documents, or records otherwise available from pharmacies or health care practitioners shall not be construed as immune from discovery or use in any civil proceedings merely because the information contained in those records was reported to the PMP in accordance with these rules.
[**ARC 7903B**, IAB 7/1/09, effective 8/5/09]

657—37.9(124) Prohibited acts. The PMP administrator shall report to the licensing board of a dispenser, a practitioner, or a practitioner's agent any known violation of the confidentiality provisions or the reporting requirements of the law and these rules for which the dispenser, practitioner, or practitioner's agent is subject to disciplinary action.

37.9(1) *Confidentiality.* A pharmacy, pharmacist, practitioner, or practitioner's agent who knowingly fails to comply with the confidentiality provisions of the law or these rules or who delegates PMP information access to another individual, except as provided in paragraph 37.4(1)*"a,"* is subject to disciplinary action by the appropriate professional licensing board. The PMP administrator or a member of the program staff who knowingly fails to comply with the confidentiality provisions of the law or these rules is subject to disciplinary action by the board. In addition to any disciplinary action or sanctions imposed by a professional licensing board, a pharmacy, pharmacist, practitioner, practitioner's agent, PMP administrator, or member of the PMP program staff who knowingly accesses, uses, or discloses program information in violation of Iowa law or these rules is subject to criminal prosecution as provided in 2011 Iowa Code Supplement section 124.558.

37.9(2) *Dispenser reporting.* A dispenser or a pharmacist who fails to comply with the reporting requirements of the law or these rules may be subject to disciplinary action by the board.
[**ARC 7903B**, IAB 7/1/09, effective 8/5/09; **ARC 0056C**, IAB 4/4/12, effective 7/1/12]

These rules are intended to implement Iowa Code sections 124.551, 124.552, and 124.554 to 124.557 and 2011 Iowa Code Supplement sections 124.553 and 124.558.

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REVENUE DEPARTMENT[701]

Created by 1986 Iowa Acts, Chapter 1245.

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[Prior to 12/17/86, Revenue Department[730]]

701—40.1(422) Net income defined. Net income for state individual income tax purposes shall mean federal adjusted gross income as properly computed under the Internal Revenue Code and shall include the adjustments in 701—40.2(422) to 701—40.9(422). The remaining provisions of this rule and 701—40.12(422) to 701—40.79(422) shall also be applicable in determining net income.

This rule is intended to implement Iowa Code section 422.7.

[**ARC 8605B**, IAB 3/10/10, effective 4/14/10; **ARC 9103B**, IAB 9/22/10, effective 10/27/10; **ARC 9820B**, IAB 11/2/11, effective 12/7/11]

701—40.2(422) Interest and dividends from federal securities. For individual income tax purposes, the state is prohibited by federal law from taxing dividends from corporations owned or sponsored by the federal government, or interest derived from obligations of the United States and its possessions, agencies, and instrumentalities. Therefore, if the federal adjusted gross income of an individual, taxable by Iowa, includes dividends or interest of this type, an adjustment must be made by deducting the amount of the dividend or interest. If the inclusion of an amount of income or the amount of a deduction is based upon federal adjusted gross income and federal adjusted gross income includes dividends from corporations owned or sponsored by the federal government, or interest derived from obligations of the United States and its possessions, agencies, and instrumentalities, a recomputation of the amount of income or deduction must be made excluding dividends or interest of this type from the calculations.

A federal statute exempts stocks and obligations of the United States Government, as well as the interest on the obligations, from state income taxation (see 31 USCS Section 3124(a)).

"Obligations of the United States" are those obligations issued "to secure credit to carry on the necessary functions of government." *Smith v. Davis* (1944) 323 U.S. 111, 119, 89 L.Ed. 107, 113, 65 S.Ct. 157, 161. The exemption is aimed at protecting the "borrowing" and "supremacy" clauses of the United States Constitution. *Society for Savings v. Bowers* (1955) 349 U.S. 143, 144, 99 L.Ed.2d 950, 955, 75 S.Ct. 607, 608; *Hibernia v. City and County of San Francisco* (1906) 200 U.S. 310, 313, 50 L.Ed. 495, 496, 26 S.Ct. 265, 266.

Tax-exempt credit instruments possess the following characteristics:

1. They are written documents,
2. They bear interest,
3. They are binding promises by the United States to pay specified sums at specified dates, and
4. They have Congressional authorization which also pledges the faith and credit of the United States in support of the promise to pay. *Smith v. Davis*, supra.

A governmental obligation that is secondary, indirect, or contingent, such as a guaranty of a nongovernmental obligor's primary obligation to pay the principal amount of and interest on a note, is not an obligation of the type exempted under 31 USCS Section 3124(1). *Rockford Life Ins. Co. v. Department of Revenue*, 107 S.Ct. 2312 (1987).

The following list contains widely held United States Government obligations, but is not intended to be all-inclusive.

This noninclusive listing indicates the position of the department with respect to the income tax status of the listed securities. It is based on current federal law and the interpretation thereof by the department. Federal law or the department's interpretation is subject to change. Federal law precludes all states from imposing an income tax on the interest income from direct obligations of the United States Government. Also, preemptive federal law may preclude state taxation of interest income from the securities of federal government-sponsored enterprises and agencies and from the obligations of U.S. territories. Any profit or gain on the sale or exchange of these securities is taxable.

40.2(1) Federal obligations and obligations of federal instrumentalities the interest on which is exempt from Iowa income tax.

a. United States Government obligations: United States Treasury—Principal and interest from bills, bonds, and notes issued by the United States Treasury exempt under 31 U.S.C. Section 3124[a].

1. Series E, F, G, H, and I bonds
2. United States Treasury bills
3. U.S. Government certificates
4. U.S. Government bonds
5. U.S. Government notes
6. Original issue discount (OID) on a United States Treasury obligation

b. Territorial obligations:

1. Guam—Principal and interest from bonds issued by the Government of Guam (48 USCS Section 1423[a]).

2. Puerto Rico—Principal and interest from bonds issued by the Government of Puerto Rico (48 USCS Section 745).

3. Virgin Islands—Principal and interest from bonds issued by the Government of the Virgin Islands (48 USCS Section 1403).

4. Northern Mariana Islands—Principal and interest from bonds issued by the Government of the Northern Mariana Islands (48 USCS Section 1681(c)).

c. Federal agency obligations:

1. Commodity Credit Corporation—Principal and interest from bonds, notes, debentures, and other similar obligations issued by the Commodity Credit Corporation (15 USCS Section 713a-5).

2. Banks for Cooperatives—Principal and interest from notes, debentures, and other obligations issued by Banks for Cooperatives (12 USCS Section 2134).

3. Farm Credit Banks—Principal and interest from systemwide bonds, notes, debentures, and other obligations issued jointly and severally by Banks of the Federal Farm Credit System (12 USCS Section 2023).

4. Federal Intermediate Credit Banks—Principal and interest from bonds, notes, debentures, and other obligations issued by Federal Intermediate Credit Banks (12 USCS Section 2079).

5. Federal Land Banks—Principal and interest from bonds, notes, debentures, and other obligations issued by Federal Land Banks (12 USCS Section 2055).

6. Federal Land Bank Association—Principal and interest from bonds, notes, debentures, and other obligations issued by the Federal Land Bank Association (12 USCS Section 2098).

7. Financial Assistance Corporation—Principal and interest from notes, bonds, debentures, and other obligations issued by the Financial Assistance Corporation (12 USCS Section 2278b-10[b]).

8. Production Credit Association—Principal and interest from notes, debentures, and other obligations issued by the Production Credit Association (12 USCS Section 2077).

9. Federal Deposit Insurance Corporation (FDIC)— Principal and interest from notes, bonds, debentures, and other such obligations issued by the Federal Deposit Insurance Corporation (12 USCS Section 1825).

10. Federal Financing Bank—Interest from obligations issued by the Federal Financing Bank. Considered to be United States Government obligations (12 USCS Section 2288, 31 USCS Section 3124[a]).

11. Federal Home Loan Bank—Principal and interest from notes, bonds, debentures, and other such obligations issued by any Federal Home Loan Bank and consolidated Federal Home Loan Bank bonds and debentures (12 USCS Section 1433).

12. Federal Savings and Loan Insurance Corporation (FSLIC)—Principal and interest from notes, bonds, debentures, and other such obligations issued by the Federal Savings and Loan Insurance Corporation (12 USCS Section 1725[e]).

13. Federal Financing Corporation—Principal and interest from notes, bonds, debentures, and other such obligations issued by the Federal Financing Corporation (12 USCS Section 2288(b)).

14. Financing Corporation (FICO)—Principal and interest from any obligation of the Financing Corporation (12 USCS Sections 1441[e][7] and 1433).

15. General Services Administration (GSA)—Principal and interest from General Services Administration participation certificates. Considered to be United States Government obligations (31 USCS Section 3124[a]).

16. Housing and Urban Development (HUD).

- Principal and interest from War Housing Insurance debentures (12 USCS Section 1739[d]).
- Principal and interest from Rental Housing Insurance debentures (12 USCS Section 1747g[g]).
- Principal and interest from Armed Services Mortgage Insurance debentures (12 USCS Section 1748b[f]).
- Principal and interest from National Defense Housing Insurance debentures (12 USCS Section 1750c[d]).
- Principal and interest from Mutual Mortgage Insurance Fund debentures (12 USCS Section 1710[d]).

17. National Credit Union Administration Central Liquidity Facility—Income from notes, bonds, debentures, and other obligations issued on behalf of the National Credit Union Administration Central Liquidity Facility (12 USCS Section 1795k[b]).

18. Resolution Funding Corporation—Principal and interest from obligations issued by the Resolution Funding Corporation (12 USCS Sections 1441[f][7] and 1433).

19. Student Loan Marketing Association (Sallie Mae)—Principal and interest from obligations issued by the Student Loan Marketing Association. Considered to be United States Government obligations (20 USCS Section 1087-2[1], 31 USCS Section 3124[a]).

20. Tennessee Valley Authority—Principal and interest from bonds issued by the Tennessee Valley Authority (16 USCS Section 831n-4[d]).

21. United States Postal Service—Principal and interest from obligations issued by the United States Postal Service (39 USCS Section 2005[d][4]).

22. Treasury Investment Growth Receipts.

23. Certificates on Government Receipts.

40.2(2) Taxable securities. There are a number of securities issued under the authority of an Act of Congress which are subject to the Iowa income tax. These securities may be guaranteed by the United States Treasury or supported by the issuing agency's right to borrow from the Treasury. Some may be backed by the pledge of full faith and credit of the United States Government. However, it has been determined that these securities are not direct obligations of the United States Government to pay a specified sum at a specified date, nor are the principal and interest from these securities specifically exempted from taxation by the respective authorizing Acts. Therefore, income from such securities is subject to the Iowa income tax. Examples of securities which fall into this category are those issued by the following agencies and institutions:

a. Federal agency obligations:

1. Federal or State Savings and Loan Associations
2. Export-Import Bank of the United States
3. Building and Loan Associations
4. Interest on federal income tax refunds
5. Postal Savings Account
6. Farmers Home Administration
7. Small Business Administration
8. Federal or State Credit Unions
9. Mortgage Participation Certificates
10. Federal National Mortgage Association
11. Federal Home Loan Mortgage Corporation (Freddie Mac)
12. Federal Housing Administration
13. Federal National Mortgage Association (Fannie Mae)
14. Government National Mortgage Association (Ginnie Mae)
15. Merchant Marine (Maritime Administration)
16. Federal Agricultural Mortgage Corporation (Farmer Mac)

b. Obligations of international institutions:

1. Asian Development Bank
2. Inter-American Development Bank

3. International Bank for Reconstruction and Development (World Bank)

c. Other obligations:

Washington D.C. Metro Area Transit Authority

Interest from repurchase agreements involving federal securities is subject to Iowa income tax. *Nebraska Department of Revenue v. John Loewenstein*, 514 US —, 130 L.Ed.2d 470, 115 S.Ct. — (1994). *Everett v. State Dept. of Revenue and Finance*, 470 N.W.2d 13 (Iowa 1991).

For tax years beginning on or after January 1, 1987, interest from Mortgage Backed Certificate Guaranteed by Government National Mortgage Association ("Ginnie Maes") is subject to Iowa income tax. See *Rockford Life Insurance Company v. Illinois Department of Revenue*, 96 L.Ed.2d 152.

For the treatment of interest or dividends from regulated investment companies (mutual funds) that invest in obligations of the type discussed in this rule, see rule 701—40.52(422).

This rule is intended to implement Iowa Code section 422.7.

[**ARC 7761B**, IAB 5/6/09, effective 6/10/09]

701—40.3(422) Interest and dividends from foreign securities, and securities of state and their political subdivisions. Interest and dividends from foreign securities and from securities of state and their political subdivisions are to be included in Iowa net income. Certain types of interest and dividends, because of specific exemption, are not includable in income for federal tax purposes. To the extent such income has been excluded for federal income tax purposes, unless the item of income is specifically exempted from state taxation by the laws or constitution of Iowa or of the United States, it must be added to Iowa taxable income.

The following is a noninclusive listing of bonds issued by the state of Iowa and its political subdivisions, interest on which is exempt from both federal and state income taxes.

1. Board of Regents: Bonds issued under Iowa Code sections 262.41, 262.51, 262.60, 262A.8, and 263A.6.

2. Urban Renewal: Bonds issued under Iowa Code section 403.9(2).

3. Municipal Housing Law - Low-income housing: Bonds issued under Iowa Code section 403A.12.

4. Subdistricts of soil conservation districts, revenue bonds: Bonds issued under Iowa Code section 467A.22 (transferred to Iowa Code section 161A.22 in 1993 Iowa Code).

5. Aviation authorities, revenue bonds: Bonds issued under Iowa Code section 330A.16.

6. Rural water districts: Bonds and notes issued under Iowa Code section 357A.15.

7. Iowa Alcoholic Beverage Control Act - Warehouse project: Bonds issued under Iowa Code section 123.159.

8. County Health Center: Bonds issued under Iowa Code section 331.441(2)*"c"*(7).

9. Iowa Finance Authority, Sewage treatment and drinking water facilities financing: Bonds issued under Iowa Code section 220.131(6) (transferred to Iowa Code section 16.131(6) in 1993 Iowa Code).

10. Agricultural Development Authority, Beginning farmer loan program: Bonds issued under Iowa Code section 175.17.

11. Iowa Finance Authority, Iowa comprehensive petroleum underground storage tank fund: Bonds issued under Iowa Code section 455G.6(14).

12. Iowa Finance Authority, E911 Program notes and bonds: Bonds issued under Iowa Code section 477B.20(6). (Transferred to Iowa Code section 34A.20(6) in 1993 Iowa Code.)

13. Quad Cities Interstate Metropolitan Authority Bonds: Bonds issued under Iowa Code section 330B.24. (Transferred to Iowa Code section 28A.24 in 1993 Iowa Code.)

14. Iowa Finance Authority, Municipal Investment Recovery Program: Bonds issued under Iowa Code section 220.173(4). (Transferred to Iowa Code section 16.173(4) in 1993 Iowa Code.)

15. Prison Infrastructure Revenue Bonds: Bonds issued under Iowa Code section 16.177(8).

16. Government Flood Damage Program Bonds: Bonds issued under Iowa Code section 16.183(4).

17. Iowa sewage treatment bonds: Bonds issued under Iowa Code section 16.131(6).

18. Community college residence halls and dormitories bonds: Bonds issued under Iowa Code section 260C.61.

19. Community college bond program bonds: Bonds issued under Iowa Code section 260C.71(6).

20. Regents institutions medical and hospital buildings at University of Iowa bonds: Bonds issued under Iowa Code section 263A.6.

21. Interstate bridges bonds: Bonds issued under Iowa Code section 313A.36.

22. Iowa higher education loan authority: Obligations issued by the authority on or after July 1, 2000, pursuant to either division of Iowa Code chapter 261A as authorized in Iowa Code section 261A.27.

23. Vision Iowa program: Bonds issued on or after July 1, 2000, upon request of the vision Iowa board pursuant to subsection 8 of Iowa Code section 12.71.

24. Honey Creek premier destination park bonds: Bonds issued under Iowa Code Supplement section 463C.12(8).

25. Iowa utilities board and Iowa consumer advocate building project bonds: Bonds issued under 2006 Iowa Acts, chapter 1179, section 70.

26. Iowa jobs program bonds: Bonds issued under 2009 Iowa Acts, Senate File 376, section 1.

Interest from repurchase agreements involving obligations of the type discussed in this rule is subject to Iowa income tax. *Nebraska Department of Revenue v. John Loewenstein*, 514 US —, 130 L.Ed. 2d 470, 115 S.Ct. — (1994). *Everett v. State Dept. of Revenue and Finance*, 470 N.W.2d 13 (Iowa 1991).

For the treatment of interest or dividends from regulated investment companies (mutual funds) that invest in obligations of the type discussed in this rule, see rule 701—40.52(422).

Gains and losses from the sale or other disposition of bonds issued by the state of Iowa or its political subdivisions, as distinguished from interest income, shall be taxable for state income tax purposes.

This rule is intended to implement Iowa Code sections 12.71, 261A.27, 357A.15, 422.7, 463C.12 and Iowa Code Supplement section 12.87.
[**ARC 8605B**, IAB 3/10/10, effective 4/14/10]

701—40.4(422) Certain pensions, annuities and retirement allowances. Rescinded IAB 11/24/04, effective 12/29/04.

701—40.5(422) Military pay.

40.5(1) Rescinded IAB 6/3/98, effective 7/8/98.

40.5(2) For income received for services performed prior to January 1, 1969, and for services performed for tax periods beginning on or after January 1, 1977, but before January 1, 2011. An Iowa resident who is on active duty in the armed forces of the United States, as defined in Title 10, United States Code, Section 101, shall include all income received for such service performed prior to January 1, 1969, and for services performed during tax periods beginning on or after January 1, 1977, but before January 1, 2011. For tax years beginning on or after January 1, 2011, see rule 701—40.76(422). However, the taxability of this active duty military income shall be terminated for any income received for services performed effective the day after either of the two following conditions:

a. When universal compulsory military service is reinstated by the United States Congress. "Compulsory military service" is defined to be the actual act of drafting individuals into the military service and not just the registration of individuals under the Military Selective Service Act (50 App. U.S.C. 453); or

b. When a state of war is declared to exist by the United States Congress.

Federal active duty does not include a member of the national guard when called for training by order of the governor through order of the adjutant general. These members are in the service of the state and not on active duty of the United States. Federal active duty also does not include members of the various military reserve programs. A taxpayer must be on active federal duty to qualify for exemption. National guard and reservists who undergo voluntary training are not on active duty in a federal status. National guard and reservist pay does not qualify for the military exemption and such pay is taxable by the state of Iowa.

Compensation received from the United States Government by nonresident members of the armed forces who are temporarily present in the state of Iowa pursuant to military orders is exempt from Iowa income tax.

This rule is intended to implement Iowa Code section 422.5.

[**ARC 9822B**, IAB 11/2/11, effective 12/7/11]

701—40.6(422) Interest and dividend income. This rule applies to interest and dividends from foreign securities and securities of state and other political subdivisions. Interest and dividends from foreign securities and from securities of state and other political subdivisions are to be included in Iowa taxable income. Certain types of interest and dividends, because of specific exemption, are not included in income for federal tax purposes. To the extent such income has been excluded for federal income tax purposes, unless the term of income is specifically exempted from state taxation by the laws or constitutions of Iowa or of the United States, it must be added to Iowa taxable income.

This rule is intended to implement Iowa Code section 422.7.

701—40.7(422) Current year capital gains and losses. In determining short-term or long-term capital gain or loss the provisions of the Internal Revenue Code are to be followed.

This rule is intended to implement Iowa Code section 422.7.

701—40.8(422) Gains and losses on property acquired before January 1, 1934. When property was acquired prior to January 1, 1934, the basis as of January 1, 1934, for determining capital or other gains or losses is the higher of cost, adjusted for depreciation allowed or allowable to January 1, 1934, or fair market value as of that date.

If, as a result of this provision, a basis is to be used for purposes of Iowa individual income tax which is different from the basis used for purposes of federal income tax, appropriate adjustment must be made and detailed schedules supplied in the computation of Iowa taxable income.

This rule is intended to implement Iowa Code section 422.7.

701—40.9(422) Work opportunity tax credit and alcohol fuel credit. Where an individual claims the work opportunity tax credit under Section 51 of the Internal Revenue Code or the alcohol fuel credit under Section 40 of the Internal Revenue Code, the amount of credit allowable must be used to increase federal taxable income. The amount of credit allowable used to increase federal adjusted gross income is deductible in determining Iowa net income. The work opportunity tax credit applies to eligible individuals who begin work after September 30, 1996, and before September 1, 2011. The adjustment for the alcohol fuel credit is applicable for tax years beginning on or after January 1, 1980.

This rule is intended to implement Iowa Code section 422.7.

701—40.10(422) Exclusion of interest or dividends. Rescinded IAB 11/24/04, effective 12/29/04.

701—40.11(422) Two-earner married couple deduction. Rescinded IAB 11/24/04, effective 12/29/04.

701—40.12(422) Income from partnerships or limited liability companies. Residents engaged in a partnership or limited liability company, even if located or doing business outside the state of Iowa, are taxable upon their distributive share of net income of such partnership or limited liability company, whether distributed or not, and are required to include such distributive share in their return. A nonresident individual who is a member of a partnership or limited liability company doing business in Iowa is taxable on that portion of net income which is applicable to the Iowa business activity whether distributed or not. See 701—Chapter 45.

This rule is intended to implement Iowa Code sections 422.7, 422.8, and 422.15.

701—40.13(422) Subchapter "S" income. Where a corporation elects, under Sections 1371-1379 of the Internal Revenue Code, to distribute the corporation's income to the shareholders, the corporation's income, in its entirety, is subject to individual reporting whether or not actually distributed. Both resident

and nonresident shareholders shall report their share of the corporation's net taxable income on their respective Iowa returns. *Isaacson v. Iowa State Tax Commission,* 183 N.W.2d 693, Iowa Supreme Court, February 9, 1971. Residents shall report their distributable share in total while nonresidents shall report only their portion of their distributable share which was earned in Iowa. For tax years beginning on or after January 1, 1996, residents should refer to 701—Chapter 50 to determine if they qualify to compute Iowa taxable income by allocation and apportionment. See 701—Chapter 54 for allocation and apportionment of corporate income.

This rule is intended to implement Iowa Code sections 422.7, 422.8, 422.15, and 422.36.

701—40.14(422) Contract sales. Interest derived as income from a land contract is intangible personal property and is assignable to the recipient's domicile. Gains received from the sale or assignment of land contracts are considered to be gains from real property in this state and are assignable to this state. As to nonresidents, see 40.16(422).

This rule is intended to implement Iowa Code sections 422.7 and 422.8.

701—40.15(422) Reporting of incomes by married taxpayers who file a joint federal return but elect to file separately for Iowa income tax purposes. Married taxpayers who have separate incomes and have filed jointly for federal income tax purposes can elect to file separate Iowa returns or to file separately on the combined Iowa return form. Where married persons file separately, both must use the optional standard deduction if either elects to use it, or both must claim itemized deductions if either elects to claim itemized deductions. The provisions of Treasury Regulation § 1.63-1 are equally applicable regarding the election to use the standard deduction or itemized deductions for Iowa income tax purposes. The spouses' election to file separately for Iowa income tax purposes is subject to the condition that incomes received by the taxpayers and the deductions for business expenses are allocated between the spouses as the incomes and deductions would have been allocated if the taxpayers had filed separate federal returns. Any Iowa additions to net income and any deductions to net income which pertain to taxpayers filing separately for Iowa income tax purposes must also be allocated accurately between the spouses. Thus, if married taxpayers file a joint federal return and elect to file separate Iowa returns or separately on the combined Iowa return, the taxpayers are required to compute their separate Iowa net incomes as if they had determined their federal adjusted gross incomes on separate federal returns with the Iowa adjustments to net income.

However, the fact that the taxpayers file separately for Iowa income tax purposes does not mean that the spouses will be subject to limitations that would apply if the taxpayers had filed separate federal returns. Instead, tax provisions that are applicable for taxpayers filing joint federal returns are also applicable to the taxpayers when they file separate Iowa returns unless the tax provisions are superseded by specific provisions in Iowa income tax law.

For example, married taxpayers that file separate federal returns cannot take the child and dependent care credit (in most instances) and cannot take the earned income credit. Taxpayers that file a joint federal return and elect to file separately for Iowa income tax purposes can take the child and dependent care credit and the earned income credit on their Iowa returns assuming they meet the qualifications for claiming these credits on the joint federal return.

The following paragraphs and examples are provided to clarify some issues and provide some guidance for taxpayers who filed a joint federal income tax return and elect to file separate Iowa returns or separately on the combined Iowa return form.

1. Election to expense certain depreciable business assets. When married taxpayers who have filed a joint federal return elect to file separate Iowa returns or separately on the combined Iowa return form, the taxpayers may claim the same deduction for the expensing of depreciable business assets as they were allowed on their joint federal return of up to $100,000 (for the tax year beginning on or after January 1, 2003, and which is adjusted annually for inflation for subsequent tax years) as authorized under Section 179 of the Internal Revenue Code. In a situation where one spouse is a wage earner and the second spouse has a small business, the second spouse may claim the same deduction for expensing depreciable assets of up to $100,000 (for the tax year beginning on or after January 1, 2003) that was allowable on the

taxpayers' joint federal return. The fact that a spouse elects to file a separate Iowa return or separately on the combined return form after filing a joint federal return does not mean the spouse is limited to the same deduction for expensing of depreciable business assets of up to $50,000 (for the tax year beginning on or after January 1, 2003) that would have applied if the spouse had filed a separate federal return.

In situations where a married couple has ownership of a business, the deduction for the expensing of depreciable assets which is allowable on the spouses' joint federal return should be allocated between the spouses in the same ratio as incomes and losses from the business are reported by the spouses. Subrule 40.15(4) sets out criteria for allocation of incomes and losses of businesses in which married couples have an ownership interest.

2. Capital losses. Except for the Iowa capital gains deduction for limited amounts of net capital gains from certain types of assets described in rule 701—40.38(422), the federal income tax provision for reporting capital gains and losses and for the carryover of capital losses in excess of certain amounts are applicable for Iowa individual income tax purposes. When married taxpayers file a joint federal income tax return and elect to file separate Iowa returns or separately on the combined return form, the spouses must allocate capital gains and losses between them on the basis of the ownership of the assets that were sold or exchanged. That is, the spouses must allocate the capital gains and losses between them on the separate Iowa returns as the capital gains and losses would have been allocated if the taxpayers had filed separate federal returns instead of a joint federal return. However, each spouse is not subject to the $1,500 capital loss limitation on the separate Iowa return which is applicable to a married taxpayer that files a separate federal return. Instead, the spouses are collectively subject to the same $3,000 capital loss limitation for married taxpayers filing joint federal returns which is authorized under Section 1211(b) of the Internal Revenue Code. In circumstances where both spouses have net capital losses, each of the spouses can claim a capital loss of up to $1,500 on the separate Iowa return. In a situation where one spouse has a net capital loss of less than $1,500 and the other spouse has a capital loss greater than $1,500, the first spouse can claim the entire capital loss, while the second spouse can claim the portion of the net capital loss on the joint federal return that was not claimed by the first spouse. In no case can the net capital losses claimed on separate Iowa returns by married taxpayers exceed the $3,000 maximum capital loss that is allowed on the joint federal return. In a circumstance where one spouse has a net capital loss and the other spouse has a net capital gain, the amounts of capital gains and losses claimed by the spouses on their separate Iowa returns must conform with the net capital gain amount or net capital loss amount claimed on the joint federal return for the taxpayers. The following examples illustrate how capital gains and losses are to be allocated between spouses filing separate Iowa returns or separately on the combined Iowa return form for married taxpayers who filed joint federal returns.

EXAMPLE 1. A married couple filed a joint federal return which showed a net capital loss of $3,000. All of the capital loss was attributable to the husband, as the wife had no capital gains or losses. Therefore, when the taxpayers filed separate Iowa returns, the husband's return showed a $3,000 capital loss and the wife's return showed no capital gains or losses.

EXAMPLE 2. A married couple filed a joint federal return showing a net capital loss of $3,000, which was the maximum loss they could claim, although they had aggregate capital losses of $8,000. The husband had a net capital loss of $6,000 and the wife had a net capital loss of $2,000. When the taxpayers filed their separate Iowa returns each spouse claimed a net capital loss of $1,500, since each spouse had a capital loss of up to $1,500. The husband had a net capital loss carryover of $4,500 and the wife had a net capital loss carryover of $500.

EXAMPLE 3. A married couple filed a joint federal return showing a net capital loss of $2,500. The husband had a net capital gain of $7,500 and the wife had a net capital loss of $10,000. The wife claimed a net capital loss of $10,000 on her separate Iowa return, while the husband reported a net capital gain of $7,500 on his separate Iowa return.

EXAMPLE 4. A married couple filed a joint federal return showing a net capital loss of $3,000. The wife had a net capital loss of $800 and the husband had a net capital loss of $2,500. The wife claimed a $800 net capital loss on her separate Iowa return. The husband claimed a net capital loss on his separate Iowa return of $2,200 which was the portion of the net capital loss claimed on the joint federal return that was not claimed by the wife. The husband had a net capital loss carryover of $300.

3. Unemployment compensation benefits. When a husband and wife have filed a joint federal return and elect to file separate Iowa returns or separately on the Iowa combined return form, the spouses are to report the same amount of unemployment compensation benefits on their Iowa returns as was reported for federal income tax purposes as provided in Section 85 of the Internal Revenue Code. When unemployment compensation benefits are received in the tax year the benefits are to be reported by the spouse or spouses who received the benefits as a result of employment of the spouse or spouses. Nonresidents of Iowa, including nonresidents covered by the reciprocal agreement with Illinois, are to report unemployment compensation benefits on the Iowa income tax return as Iowa source income to the extent the benefits pertain to the individual's employment in Iowa. In a situation where the unemployment compensation benefits are the result of employment in Iowa and in one or more other states, the unemployment compensation benefits should be allocated to Iowa on the basis of the individual's Iowa salaries and wages for the employer to the total salaries and wages for the employer. However, to the extent that unemployment compensation benefits pertain to a person's employment in Iowa for a railroad and the benefits are paid by the railroad retirement board, the benefits are totally exempt from Iowa income tax pursuant to 45 U.S.C. Section 352(e).

40.15(1) *Income from property in which only one spouse has an ownership interest but which is not used in business.* If ownership of property not used in a business is in the name of only one spouse and each files a separate state return, income derived from such property may not be divided between husband and wife but must be reported by only that spouse possessing the ownership interest.

40.15(2) *Income from property in which both husband and wife have an ownership interest but which is not used in a business.* A husband and wife who file a joint federal return and elect to file separate Iowa returns must each report the share of income from jointly or commonly owned real estate, stocks, bonds, bank accounts, and other property not used in a business in the same manner as if their federal adjusted gross incomes had been determined separately. The rules for determining the manner of reporting this income depend upon the nature of the ownership interest and, in general, may be summarized as follows:

a. Joint tenants. A husband and wife owning property as joint tenants with the right of survivorship, a common example of which is a joint savings account, should each report on separate returns one-half of the income from the savings account held by them in joint tenancy.

b. Tenants in common. Income from property held by husband and wife as tenants in common is reportable by them in proportion to their legally enforceable ownership interests in the property.

40.15(3) *Salary and wages derived from personal or professional services performed in the course of employment.* A husband and wife who file a joint federal return and elect to file separate Iowa returns must report on each spouse's state return the salary and wages which are attributable to services performed pursuant to each individual's employment. The income must be reported on Iowa separate returns in the same manner as if their federal adjusted gross incomes had been determined separately. The manner of reporting wages and salaries by spouses is dependent upon the nature of the employment relationship and is subject to the following rules:

a. Interspousal employment—salary or wages paid by one spouse to the other. Wages or compensation paid for services or labor performed by one spouse with respect to property or business owned by the other spouse may be reported on a separate return if the amount of the payment is reasonable for the services or labor actually performed. It is presumed that the compensation or wages paid by one spouse to the other is not reasonable nor allowable for purposes of reporting the income separately unless a bona fide employer-employee relationship exists. For example, unless actual services are rendered, payments are actually made, working hours and standards are set and adhered to, unemployment compensation and workers' compensation requirements are met, the payments may not be separately reported by the salaried spouse.

b. Wages and salaries received by a husband or wife pursuant to an employment agreement with an employer other than a spouse. Wages or compensation paid for services or labor performed by a husband or wife pursuant to an employment agreement with some other employer is presumed income of only that spouse that is employed and must be reported separately only by that spouse.

40.15(4) *Income from a business in which both husband and wife have an ownership interest.* Income derived from a business the ownership of which is in both spouses' names, as

evidenced by record title or by the existence of a bona fide partnership agreement or by other recognized method of establishing legal ownership, may be allocated between spouses and reported on separate individual state income tax returns provided that the interest of each spouse is allocated according to the capital interest of each, the management and control exercised by each, and the services performed by each with respect to such business. Compliance with the conditions contained in paragraphs *"a"* or *"b"* of this subrule and consideration of paragraphs *"c," "d,"* and *"e"* of this subrule must be made in allocating income from a business in which both husband and wife have an ownership interest.

a. Allocation of partnership income. Allocation of partnership income between spouses is presumed valid only if partnership information returns, as required for income tax purposes, have currently been filed with respect to the federal self-employment tax law. An oral understanding does not constitute a bona fide partnership implied merely from a common ownership of property.

b. Allocation of income derived from a business other than a partnership in which both husband and wife claim an ownership interest. In the case of a business owned by a husband and wife who filed a joint federal income tax return in which one of them claimed all of the income therefrom for federal self-employment tax purposes, it will be presumed for purposes of administering the state income tax law, unless expressly shown to the contrary by the taxpayer, that the spouse who claimed that income for federal self-employment tax purposes did, thereby, with the consent of the other spouse, claim all right to such income and that therefore such income must be included in the state income tax return of the spouse who claimed it for federal self-employment tax purposes if the husband and wife file separate state income tax returns.

c. Capital contribution. In determining the weight to be attributed to the capital contribution of each spouse to a business, consideration may be given only to that invested capital which is legally traceable to each individual spouse. Capital existing under the right, dominion, and control of one spouse which is invested in the business is presumed to be a capital contribution of that spouse. Sham transactions which do not affect real changes of ownership in capital between spouses in that such transactions do not legally disturb the right, dominion, and control of the assignor or the donor over the capital must be disregarded in determining capital contribution of the recipient spouse.

d. Management and control. Participation in the control and management of a business must be distinguished from the regular performance of nonmanagerial services. Contribution of management and control with respect to the business must be of a substantial nature in order to accord it weight in making an allocation of income. Substantial participation in management does not necessarily involve continuous or even frequent presence at the place of business, but it does involve genuine consultation with respect to at least major business decisions, and it presupposes substantial acquaintance with an interest in the operations, problems, and policies of the business, along with sufficient maturity and background of education or experience to indicate an ability to grasp business problems that are appreciably commensurate with the demands of the enterprise concerned. Vague or general statements as to family discussions at home or elsewhere will not be accepted as a sufficient showing of actual consultation.

e. Services performed. The amount of services performed by each spouse is a factor to be considered in determining proper allocation of income from a business in which each spouse has an ownership interest. In order to accord weight to services performed by an individual spouse, the services must be of a beneficial nature in that they make a direct contribution to the business. For example, for a business operation, whether it is a retail sales enterprise, farming operation or otherwise, in which both husband and wife have an ownership interest, the services contributed by the spouses must be directly connected with the business operation. Services for the family such as planting and maintaining family gardens, domestic housework, cooking family meals, and routine errands and shopping, are not considered to be services performed or rendered as an incident of or a contribution to the particular business; such activities by a spouse must be disregarded in determining the allocable income attributable to that spouse.

This rule is intended to implement Iowa Code section 422.7.

[**ARC 8356B**, IAB 12/2/09, effective 1/6/10]

701—40.16(422) Income of nonresidents. Except as otherwise provided in this rule all income of nonresidents derived from sources within Iowa is subject to Iowa income tax.

Net income received by a nonresident taxpayer from a business, trade, profession, or occupation in Iowa must be reported.

Income from the sale of property, located in Iowa, including property used in connection with the trade, profession, business or occupation of the nonresident, is taxable to Iowa even though the sale is consummated outside of Iowa, and provided that the property was sold before subsequent use outside of Iowa. Any income from the property prior to its sale is also Iowa taxable income.

Income received from a trust or an estate, where the income is from Iowa sources, is taxable, regardless of the situs of the estate or trust. Dividends received in lieu of, or in partial or full payment of, an amount of wages or salary due for services performed in Iowa by a nonresident shall be considered taxable Iowa income. Annuities, interest on bank deposits and interest-bearing obligations, and dividends are not allocated to Iowa except to the extent to which they are derived from a business, trade, profession, or occupation carried on within the state of Iowa by the nonresident.

Interest received from the sale of property, on an installment contract even though the gain from the sale of the property is subject to Iowa taxation, is not allocable to Iowa if the property is not part of the nonresident's trade, profession, business or occupation. As to residents, see 40.14(422).

40.16(1) *Nonresidents exempt from paying tax.* See 701—subrules 39.5(10) and 39.5(11) for the net income exemption amounts for nonresidents.

These provisions for reducing tax in 701—subrule 39.5(10), paragraph *"c,"* and 701—subrule 39.5(11), paragraph *"b,"* do not apply to the Iowa minimum tax which must be paid irrespective of the amount of Iowa income that an individual has.

40.16(2) *Compensation for personal services of nonresidents.* The Iowa income of a nonresident must include compensation for personal services rendered within the state of Iowa. The salary or other compensation of an employee or corporate officer who performs services related to businesses located in Iowa, or has an office in Iowa, are not subject to Iowa tax, if the services are performed while the taxpayer is outside of Iowa. However, the salary earned while the nonresident employee or officer is located within the state of Iowa would be subject to Iowa taxation. The Iowa taxable income of the nonresident shall include that portion of the total compensation received from the employer for personal services for the tax year which the total number of working days that the individual was employed within the state of Iowa bears to the total number of working days within and without the state of Iowa.

Compensation paid by an Iowa employer for services performed wholly outside of Iowa by a nonresident is not taxable income to the state of Iowa. However, all services performed within Iowa, either part-time or full-time, would be taxable to the nonresident and must be reported to this state.

Compensation received from the United States Government by a nonresident member of the armed forces is explained in 40.5(422).

Income from commissions earned by a nonresident traveling salesperson, agent or other employee for services performed or sales made and whose compensation depends directly on the volume of business transacted by the nonresident will include that proportion of the compensation received which the volume of business transacted by the employee within the state of Iowa bears to the total volume of business transacted by the employee within and without the state. Allowable deductions will be apportioned on the same basis. However, where separate accounting records are maintained by a nonresident or the employer of the business transacted in Iowa, then the amount of Iowa compensation can be reported based upon separate accounting.

Nonresident actors, singers, performers, entertainers, wrestlers, boxers (and similar performers), must include as Iowa income the gross amount received for performances within this state.

Nonresident attorneys, physicians, engineers, architects (and other similar professions), even though not regularly employed in this state, must include as Iowa income the entire amount of fees or compensation received for services performed in this state.

If nonresidents are employed in this state at intervals throughout the year, as would be the case if employed in operating trains, planes, motor buses, or trucks and similar modes of transportation, between this state and other states and foreign countries, and who are paid on a daily, weekly or monthly basis, the

gross income from sources within this state is that portion of the total compensation for personal services which the total number of working days employed within the state bears to the total number of working days both within and without the state. If paid on a mileage basis, the gross income from sources within this state is that portion of the total compensation for services which the number of miles traveled in Iowa bears to the total number of miles traveled both within and without the state. If paid on some other basis, the total compensation for personal services must be apportioned between this state and other states and foreign countries in such a manner as to allocate to Iowa that portion of the total compensation which is reasonably attributable to personal services performed in this state. Any alternative method of allocation is subject to review and change by the director. However, pursuant to federal law, nonresidents who earn compensation in Iowa and one or more other states for a railway company, an airline company, a merchant marine company, or a motor carrier are only subject to the income tax laws of their state of residence, and the compensation would not be considered gross income from sources within Iowa.

40.16(3) *Income from business sources within and without the state.* When income is derived from any business, trade, profession, or occupation carried on partly within and partly without the state only such income as is fairly and equitably attributable to that portion of the business, trade, profession, or occupation carried on in this state, or to services rendered within the state shall be included in the gross income of a nonresident taxpayer. In any event, the entire amount of such income both within and without the state is to be shown on the nonresident's return.

40.16(4) *Apportionment of business income from business carried on both within and without the state.*

a. If a nonresident, or a partnership or trust with a nonresident member, transacts business both within and without the state, the net income must be so apportioned as to allocate to Iowa a portion of the income on a fair and equitable basis, in accordance with approved methods of accounting.

b. The amount of net income attributable to the manufacture or sale of tangible personal property shall be that portion which the gross sales made within the state bears to the total gross sales. The gross sales of tangible personal property are in the state if the property is delivered or shipped to a purchaser within this state, regardless of the F.O.B. point or other conditions of the sale.

c. Income derived from business other than the manufacture or sale of tangible personal property shall be attributed to Iowa in that portion which the Iowa gross receipts bear to the total gross receipts. Gross receipts are attributable to this state in the portion which the recipient of the service receives benefit of the service in this state.

d. If the taxpayer believes that the gross sales or gross receipts methods subjects the taxpayer to taxation on a greater portion of net income than is reasonably attributable to the business within this state the taxpayer may request the use of separate accounting or another alternative method which the taxpayer believes to be proper under the circumstances. In any event, the entire income received by the taxpayer and the basis for a special method of allocation shall be disclosed in the taxpayer's return.

40.16(5) *Income from intangible personal property.* Business income of nonresidents from rentals or royalties for the use of, or the privilege of using in this state, patents, copyrights, secret processes and formulas, goodwill, trademarks, franchises, and other like property is income from sources within the state.

Income of nonresidents from intangible personal property such as shares of stock in corporations, bonds, notes, bank deposits and other indebtedness is not taxable as income from sources within this state except where such income is derived from a business, trade, profession, or occupation carried on within this state by the nonresident. If a nonresident buys or sells stocks, bonds, or other such property, so regularly, systematically and continuously as to constitute doing business in this state, the profit or gain derived from such activity is taxable as income from a business carried on within Iowa.

Following are examples to illustrate when intangible income may or may not be subject to the allocation provisions of Iowa Code section 422.8 and rules 701—40.15(422) and 701—42.5(422):

EXAMPLE A - An Illinois resident is a laborer at a factory in Davenport. A $50 payroll deduction is made each week from the laborer's paycheck to the company's credit union. The Illinois resident will earn $600 in interest income from the Iowa credit union account in 1983. The interest income would

not be included in the net income allocated to Iowa since the interest income is not derived from the taxpayer's business or utilized for business purposes.

EXAMPLE B - A Nebraska resident is a self-employed plumber, who has a plumbing business in Council Bluffs. The plumber has an interest-bearing checking account in an Iowa bank which the plumber uses to pay bills for the plumbing business. The plumber will earn $200 in interest income from the checking account in 1982. The plumber will have a net income of $25,000 from the plumbing business which will be reported on the plumber's 1982 Iowa return. The interest income earned by this nonresident would be taxable to Iowa since it is derived from the business and is utilized in the business.

EXAMPLE C - An Illinois resident has a farm in Illinois. The Illinois resident has an account in an Iowa savings and loan association and invests earnings from the Illinois farm in the Iowa savings and loan account. In 1982, the Illinois farmer will earn $1,000 in interest income from the account in the Iowa savings and loan. The interest income is not included in the net income allocable to Iowa since the interest income is not derived from the taxpayer's trade or business.

EXAMPLE D - An Illinois resident has Iowa farms. The Illinois resident invests the profits from the farms in a savings account in an Iowa bank. Several times a year, the taxpayer transfers part of the funds from the savings account to the taxpayer's checking account to purchase machinery to be used in the farming operations. The interest income would not be included in income allocated to Iowa since the interest income is not derived from the taxpayer's trade or business nor is the savings account utilized as a business account.

EXAMPLE E - An Illinois resident is a physician, whose practice is in Iowa. The physician has a business checking account in an Iowa bank that is used to pay the bills relating to the physician's practice. In the same bank, the physician has a personal savings account where all the physician's receipts for a given month are deposited. On the first working day of the month, funds are transferred from the savings account to the checking account to pay the bills that have accrued during the month. The interest income from the savings account would be included in net income allocated to Iowa since it is derived from and utilized in the business.

EXAMPLE F - A nonresident has a farm in Iowa which is the nonresident's principal business, although this person is an Illinois resident. The nonresident has an interest-bearing checking account in an Iowa bank. This checking account is used to pay personal expenditures as well as to pay expenses incurred in operation of the farm. In 1982, the taxpayer will earn $550 in interest from the checking account. The interest would be included in net income allocated to Iowa since the interest is derived from the business, generated from a business account, and utilized in the business.

Income of a nonresident beneficiary from an estate or trust, distributed or distributable to the beneficiary out of income from intangible personal property of the estate or trust, is not income from sources in this state and is not taxable to the nonresident beneficiary unless the property is so used by the estate or trust as to create a business, trade, profession, or occupation in this state.

Whether or not the executor or administrator of an estate or the trustee of a trust is a resident of this state is immaterial, insofar as the taxation of income of beneficiaries from the estate or trust are concerned.

EXAMPLE G - A nonresident is a partner in a family investment partnership in which the other partners are members of the same family. The other partners are residents of Iowa. The partnership invests in mutual funds, interest-bearing securities and stocks which produce interest, dividend and capital gain income for the partnership. The partners who are Iowa residents make occasional decisions in Iowa on what investments should be made by the partnership. The distributive share of interest, dividend and capital gain income reported by the nonresident would not be included in net income allocated to Iowa since it was not derived from a business carried on within the state.

40.16(6) *Distributive shares of nonresident partners.* When a partnership derives income from sources within this state as determined in 40.16(3) to 40.16(5), the nonresident members of the partnership are taxable only upon that portion of their distributive share of the partnership income which is derived from sources within this state.

40.16(7) *Interest and dividends from government securities.* Interest and dividends from federal securities subject to the federal income tax under the Internal Revenue Code are not to be included in

determining the Iowa net income of a nonresident, but any interest and dividends from securities and from securities of state and other political subdivisions exempt for federal income tax under the Internal Revenue Code are to be included in the Iowa net income of a nonresident to the extent that same are derived from a business, trade, profession, or occupation carried on within the state of Iowa by the nonresident.

40.16(8) *Gains or losses from sales or exchanges of real property and tangible personal property by a nonresident of Iowa.* If a nonresident realizes any gains or losses from sales or exchanges of real property or tangible personal property within the state of Iowa, such gains or losses are subject to the Iowa income tax and shall be reported to this state by the nonresident. Gains or losses attributable to Iowa will be determined as follows:

1. Gains or losses from sales or exchanges of real property located in this state are allocable to this state.

2. Capital gains and losses from sales or exchanges of tangible personal property are allocable to this state if the property had a situs in this state at the time of the sale.

In determining whether a short-term or long-term capital gain or a capital loss is involved in a sale or exchange, and determining the amount of a gain from the sale of real or tangible property in Iowa, the provisions of the Internal Revenue Code are to be followed.

40.16(9) *Capital gains or losses from sales or exchanges of ownership interests in Iowa business entities by nonresidents of Iowa.* Nonresidents of Iowa who sell or exchange ownership interests in various Iowa business entities will be subject to Iowa income tax on capital gains and capital losses from those transactions for different entities as described in the following paragraphs:

a. Capital gains from sales or exchanges of stock in C corporations and S corporations. When a nonresident of Iowa sells or exchanges stock in a C corporation or an S corporation, that shareholder is selling or exchanging the stock, which is intangible personal property. The capital gain received by a nonresident of Iowa from the sale or exchange of capital stock of a C corporation or an S corporation is taxable to the state of the personal domicile or residence of the owner of the capital stock unless the stock attains an independent business situs apart from the personal domicile of the individual who sold the capital stock. The stock may acquire an independent business situs in Iowa if the stock had been used as an integral part of some business activity occurring in Iowa in the year in which the sale or exchange of the stock had taken place. Whether the stock has attained an independent business status is determined on a factual basis.

For example, a situation in which capital stock owned by a nonresident of Iowa was used as collateral to secure a loan to remodel a retail store in Iowa, regardless of the ownership of the store, would meet the test for the stock being used as an integral part of some business activity in Iowa.

Assuming that the gain from the sale or exchange of stock is attributable to Iowa, the next step is to determine how much of the gain is attributable to Iowa. This is computed on the basis of the Iowa allocation and apportionment rules applicable to the separate business the stock has become an integral part of for the year in which the sale or exchange occurred. For example, if the business was subject to Iowa income tax on 40 percent of its income in the year of the sale or exchange, then 40 percent of the capital gain would be attributable or taxable by Iowa.

However, the fact that the gain from the sale or exchange of stock is taxable or partially taxable to Iowa does not mean that the dividends received by the nonresident in the year of sale are taxable to Iowa. Dividends from stock used in an Iowa specific business activity would not be taxable to Iowa except under special circumstances. An illustration of these special circumstances would be when the dividends are from capital stock from a business where the purchase and sale of stock constitute a regular business in Iowa. In this situation the dividends would be taxable to Iowa. See subrule 40.16(5).

b. Capital gains from sales or exchanges of interests in partnerships. When a nonresident of Iowa sells or exchanges the individual's interest in a partnership, the nonresident is actually selling an intangible since the partnership can continue without the nonresident partner and the assets used by the partnership are legally owned by the partnership and an individual retains only an equitable interest in the assets of the partnership by virtue of the partner's ownership interest in the partnership. However, because of the unique attributes of partnerships, the owner's interest in a partnership is considered to

be localized or "sourced" at the situs of the partnership's activities as a matter of law. *Arizona Tractor Co. v. Arizona State Tax Com'n.,* 566 P.2d 1348, 1350 (Ariz. App. 1997); Iowa Code chapter 486 (unique attributes of a partnership defined). Therefore, if a partnership conducts all of its business in Iowa, 100 percent of the gain on the sale or exchange of a partnership interest would be attributable to Iowa. On the other hand, if the partnership conducts 100 percent of its business outside of Iowa, none of the gain would be attributable to Iowa for purposes of the Iowa income tax. In the situation where a partnership conducts business both in and out of Iowa, the capital gain from the sale or exchange of an interest in the partnership would be allocated or apportioned in and out of Iowa based upon the partnership's activities in and out of Iowa in the year of the sale or exchange.

Note that if a partnership is a publicly traded partnership and is taxed as a corporation for federal income tax purposes, any capital gains realized on the sale or exchange of a nonresident partner's interest in the partnership will receive the same tax treatment as the capital gain from the sale or exchange of an interest in a C corporation or an S corporation as specified in paragraph *"a"* of this subrule.

c. Capital gains from sales or exchanges of sole proprietorships. When a nonresident sells or exchanges the individual's interest in a sole proprietorship, the nonresident is actually selling or exchanging tangible and intangible personal property used in this business because the sole proprietor is the legal and equitable owner of all such assets. Therefore, the general source or situs rules governing the gain from the sale or exchange of tangible property and intangible property by a nonresident individual control. Thus, if the sole proprietorship is located in Iowa, the gain from the sale or exchange of the proprietorship by a nonresident would be taxable to Iowa.

d. Capital gains from sales or exchanges of interests in limited liability companies. Limited liability companies are hybrid business entities containing elements of both a partnership and a corporation. If a limited liability company properly elected to file or would have been required to file a federal partnership tax return, a capital gain from the sale or exchange of an ownership interest in the limited liability company by a nonresident member of the company would be taxable to Iowa to the same extent as if the individual were selling a similar interest in a partnership as described in paragraph *"b"* of this subrule. However, if the limited liability company properly elected or would have been required to file a federal corporation tax return, a nonresident member who sells or exchanges an ownership interest in the limited liability company would be treated the same as if the nonresident were selling a similar interest in a C corporation or an S corporation as described in paragraph *"a"* of this subrule.

e. Taxation of corporate liquidations. As a matter of Iowa law, the proceeds from corporate liquidating distributions are not considered to be the proceeds from the sale or exchange of corporate stock. Rather, such proceeds represent the transfer back to the shareholder of that shareholder's pro-rata share of the actual assets of the corporation in which each shareholder held only an equitable ownership interest prior to the dissolution. *Lynch v. State Board of Assessment and Review,* 228 Iowa 1000, 1003-1004, 291 N.W. 161 (1940). The amount of such gain is calculated by subtracting the distribution realized from the shareholder's basis in the stock. Id. Thus, any gain realized by the shareholder upon such distribution is considered a capital gain from a sale or exchange of the assets by the shareholder for purposes of sourcing the shareholder's liquidating distribution gain. Consequently, the gain, whether it is from a distribution of cash or other property, is controlled by the general source or situs rules in subrule 40.16(8) governing the taxation of the sale or exchange of tangible personal property by a nonresident and subrule 40.16(10) governing the sale or exchange of intangible personal property by a nonresident.

f. Capital losses realized by a nonresident of Iowa from the sale or exchange of an ownership interest in an Iowa business entity. In a situation where a nonresident of Iowa sells the ownership interest in an Iowa business entity and has a capital loss from the transaction, the nonresident can claim the loss on the Iowa income tax return under the same circumstances that a capital gain would have been reported as described in paragraphs *"a"* through *"e"* of this subrule. The federal income tax provisions for netting Iowa source capital gains and losses are applicable as well as the federal provisions for limiting the net capital loss in the tax year to $3,000, with the carryover of the portion of net capital losses that exceed $3,000.

40.16(10) *Capital gains and losses from sales or exchanges of intangible personal property other than ownership interests in business entities.* Capital gains and losses realized by a nonresident of Iowa from the sale or exchange of intangible personal property (other than interests in business entities) are taxable to Iowa if the intangible property was an integral part of some business activity occurring regularly in Iowa prior to the sale or exchange. In the case of an intangible asset which was an integral part of a business activity of a business entity occurring regularly within and without Iowa, a capital gain or loss from the sale or exchange of the intangible asset by a nonresident of Iowa would be reported to Iowa in the ratio of the Iowa business activity to the total business activity for the year of the sale.

This rule is intended to implement Iowa Code sections 422.5, 422.7, and 422.8.

[**ARC 7761B**, IAB 5/6/09, effective 6/10/09; **ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9103B**, IAB 9/22/10, effective 10/27/10]

701—40.17(422) Income of part-year residents. A taxpayer who was a resident of Iowa for only a portion of the taxable year is subject to the following rules of taxation:

1. For that portion of the taxable year for which the taxpayer was a nonresident, the taxpayer shall allocate to Iowa only the income derived from sources within Iowa.

2. For that portion of the taxable year for which the taxpayer was an Iowa resident, the taxpayer shall allocate to Iowa all income earned or received whether from sources within or without Iowa.

A taxpayer moving into Iowa may adjust the Iowa-source gross income on Schedule IA 126 by the amount of the moving expense to the extent allowed by Section 217 of the Internal Revenue Code. Any reimbursement of moving expense shall be included in Iowa-source gross income. A taxpayer moving from Iowa to another state or country may not adjust the Iowa-source gross income by the amount of moving expense, nor should any reimbursement of moving expense be allocated to Iowa.

This rule is intended to implement Iowa Code sections 422.5, 422.7, and 422.8.

701—40.18(422) Net operating loss carrybacks and carryovers. Net operating losses shall be allowed or allowable for Iowa individual income tax purposes and will be computed using a method similar to the method used to compute losses allowed or allowable for federal income tax purposes. In determining the applicable amount of Iowa loss carrybacks and carryovers, the adjustments to net income set forth in Iowa Code section 422.7 and the deductions from net income set forth in Iowa Code section 422.9 must be considered.

40.18(1) *Treatment of federal income taxes.*

a. Refund of federal income taxes due to net operating loss carrybacks or carryovers shall be reflected in the following manner:

(1) Accrual basis taxpayers shall accrue refunds of federal income taxes to the year in which the net operating loss occurs.

(2) Cash basis taxpayers shall reflect refunds of federal income taxes in the return for the year in which the refunds are received.

(3) Refunds reported in the year in which the net operating loss occurs which contain both business and nonbusiness components shall be analyzed and separated accordingly. The amount of refund attributable to business income shall be that amount of federal taxes paid on business income which are being refunded.

b. Federal income taxes paid in the year of the loss which contain both business and nonbusiness components shall be analyzed and separated accordingly. Federal income taxes paid in the year of the loss shall be reflected as a deduction to business income to the extent that the federal income tax was the result of the taxpayer's trade or business. Federal income taxes paid which are not attributable to a taxpayer's trade or business shall also be allowed as a deduction but will be limited to the amount of gross income which is not derived from a trade or business.

40.18(2) *Nonresidents doing business within and without Iowa.* If a nonresident does business both within and without Iowa, the nonresident shall make adjustments reflecting the apportionment of the operating loss on the basis of business done within and without the state of Iowa, according to rule 40.16(422). The apportioned income or loss shall be added or deducted, as the case may be, to any amount of other income attributable to Iowa for that year.

40.18(3) *Loss carryback and carryforward.* The net operating loss attributable to Iowa as determined in rule 40.18(422) shall be subject to the federal 2-year carryback and 20-year carryover provisions if the net operating loss was for a tax year beginning after August 5, 1997, or subject to the federal 3-year carryback and the 15-year carryforward provisions if the net operating loss was for a tax year beginning prior to August 6, 1997. However, in the case of a casualty or theft loss for an individual taxpayer or for a net operating loss in a presidentially declared disaster area incurred by a taxpayer engaged in a small business or in the trade or business of farming, the net operating loss is to be carried back 3 taxable years and forward 20 taxable years if the loss is for a tax year beginning after August 5, 1997. The net operating loss or casualty or theft loss shall be carried back or over to the applicable year as a reduction or part of a reduction of the taxable income attributable to Iowa for that year. However, a net operating loss shall not be carried back to a year in which the taxpayer was not doing business in Iowa. If the election under Section 172(b)(3) of the Internal Revenue Code is made, the Iowa net operating loss shall be carried forward 20 taxable years if the net operating loss is for a tax year beginning after August 5, 1997, or the net operating loss shall be carried forward 15 taxable years if the loss is for a tax year beginning before August 6, 1997. A copy of the federal election made under Section 172(b)(3) of the Internal Revenue Code must be attached to the Iowa individual return filed with the department.

40.18(4) *Loss not applicable.* No part of a net loss for a year for which an individual was not subject to the imposition of Iowa individual income tax shall be included in the Iowa net operating loss deduction applicable to any year prior to or subsequent to the year of the loss.

40.18(5) *Special adjustments applicable to net operating losses.* Section 172(d) of the Internal Revenue Code provides for certain modifications when computing a net operating loss. These modifications refer to, but are not limited to, such things as considerations of other net operating loss deductions, treatment of capital gains and losses, and the limitation of nonbusiness deductions. Where applicable, the modifications set forth in Section 172 of the Internal Revenue Code shall be considered when computing the net operating loss carryover or carryback for Iowa income tax purposes.

40.18(6) *Distinguishing business or nonbusiness items.* In computing a net operating loss, nonbusiness deductions may be claimed only to the extent of nonbusiness income. Therefore, it is necessary to distinguish between business and nonbusiness income and expenses. For Iowa net operating loss purposes, an item will retain the same business or nonbusiness identity which would be applicable for federal income tax purposes.

40.18(7) *Examples.* The computation of a net operating loss deduction for Iowa income tax purposes is illustrated in the following examples:

a. Individual A had the following items of income for the taxable year:

Gross income from retail sales business		$125,000
Interest income from federal securities		2,000
Salary from part-time job		12,500
Individual A's federal return showed the following deductions:		
Business deductions (retail sales)		$150,000
Itemized (nonbusiness) deductions:		
Interest	$400	
Real estate tax	600	
Iowa income tax	800	$ 1,800

Individual A paid $3,000 federal income tax during the year which consisted of $2,500 federal withholding (business) and a $500 payment (nonbusiness) which was for the balance of the prior year's federal tax liability.

The federal computations are as follows:

	Per Return	Computed NOL
Income:		
Retail Sales	$125,000	$125,000
Interest income-federal securities	2,000	2,000
Salary	12,500	12,500
Subtotal	$139,500	$139,500
Deductions:		
Business	$150,000	$150,000
Itemized deductions	1,800	1,800
(Loss) per federal	($ 12,300)	
Computed net operating loss		($ 12,300)

Since the nonbusiness deductions do not exceed the nonbusiness income, the loss per the federal return and the computed net operating loss are the same.

The Iowa computations are as follows:

	Per Return	Computed NOL
Income:		
Retail sales	$125,000	$125,000
Salary	12,500	12,500
Subtotal	$137,500	$137,500
Deductions:		
Business	$150,000	$150,000
Federal tax deductions	3,000	2,500
Itemized deductions	1,000	-
(Loss) per return	($ 16,500)	
Computed Iowa NOL		($ 15,000)

NOTE: Itemized (nonbusiness deductions) are eliminated due to the lack of nonbusiness income. The only nonbusiness income, interest from federal securities, is not taxable for Iowa income tax purposes under Iowa Code section 422.7. The only federal tax deduction allowable is that related to business activity.

b. Individual B had the following items of income for the taxable year:

Gross income from restaurant business	$300,000
Wages	12,000
Business long-term capital gain @100%	1,000
Municipal bond interest (nonbusiness)	1,000
Federal tax refund of prior year taxes	500
Iowa tax refund of prior year taxes	100
Individual B's federal return showed the following deductions:	
Business deductions from restaurant	$333,000
Itemized deductions:	

Interest (nonbusiness)	$590	
Real estate tax (nonbusiness)	780	
Iowa income tax*	520	
Alimony (nonbusiness)	600	
Union dues (business)	100	2,590

*Iowa estimated payments totaled $220 of which $70 related to nonbusiness income and $150 related to business capital gains and business profits. $300 in Iowa tax was withheld from his wages.

Individual B paid $2,000 in federal income taxes during the tax year. $1,500 of this amount was withholding on wages and $500 was a federal estimated payment based on capital gains and projected business profits.

In the previous year 75 percent of B's income was from business sources and 25 percent was from nonbusiness sources.

The federal computations are as follows:

	Per Return	Computed NOL
Income:		
Retail sales	$300,000	$300,000
Wages	12,000	12,000
Capital gains	500(a)	1,000(a)
Iowa refund	100	100
Subtotal	$312,600	$313,100
Deductions:		
Business	$333,000	$333,000
Itemized deductions	2,590	575(b)
(Loss) per federal	($ 22,990)	
Computed net operating loss		($ 20,475)

(a) Capital gains are reduced by 50 percent in computing adjusted gross income, but must be reported in full in computing a net operating loss.

(b) Itemized deductions are limited to business deductions consisting of $100 for union dues, $450 for Iowa tax on business income, and nonbusiness deductions to the extent of nonbusiness income which amounts to $25. The only nonbusiness income is 25 percent of the $100 Iowa refund.

The Iowa computations are as follows:

	Per Return	Computed NOL
Income:		
Retail sales	$300,000	$300,000
Wages	12,000	12,000
Capital gains	500	1,000
Municipal bond interest	1,000	1,000
Federal refund	500	500
Subtotal	$314,000	$314,500

Deductions:		
Business	$333,000	$333,000
Federal tax	2,000	2,000
Itemized deductions	2,070(c)	1,225(d)
(Loss) per return	($ 23,070)	
Computed Iowa NOL		($ 21,725)

(c) Iowa income tax is not an itemized deduction for Iowa income tax purposes.

(d) Itemized deductions are limited to business deductions of $100 for union dues and nonbusiness deductions to the extent of nonbusiness income of $1,125. Nonbusiness income includes $1,000 of municipal bond interest and 25 percent ($125) of the federal tax refund.

40.18(8) *Net operating losses for nonresidents and part-year residents for tax years beginning on or after January 1, 1982.* For tax years beginning on or after January 1, 1982, nonresidents and part-year residents may carryback/carryforward only those net operating losses from Iowa sources. Nonresidents and part-year residents may not carryback/carryforward net operating losses which are from all sources.

Before the Iowa net operating loss of a nonresident or part-year resident is available for carryback/carryforward to another tax year, the loss must be decreased or increased by a number of possible adjustments depending on which adjustments are applicable to the taxpayer for the year of the loss. Iowa Net Operating Loss (NOL) Worksheet (41-123) may be used to make the adjustments to the net operating loss and compute the net operating loss deduction available for carryback/carryforward.

If the net operating loss was increased by an adjustment for an individual retirement account or H.R.10 retirement plan, the net operating loss should be decreased by the amount of the adjustment. The net operating loss should also be decreased by the amount of any capital loss or by the capital gain deduction to the extent the capital loss or capital gain deduction was from the sale or exchange of an asset from an Iowa source.

In a situation where the nonresident or part-year resident taxpayer received a federal income tax refund in the year of the NOL, the refund should reduce the loss in the ratio of the Iowa source income to the all source income for the tax year in which the refund was generated.

The net operating loss should be increased by any federal income tax paid in the loss year for a prior year in the ratio of the Iowa income for the prior year to the all source income for the prior year. Federal income tax withheld from wages or other compensation received in the loss year may be used to increase the Iowa net operating loss to the extent the tax is withheld from wages or other compensation earned in Iowa.

Federal estimate tax payments would be allocated to Iowa and increase the net operating loss on the basis of the Iowa income not subject to withholding to total income not subject to withholding. In any case where this method of allocation of federal estimate payments to Iowa is not considered to be equitable, the taxpayer may allocate the payments using another method as long as this method is disclosed on the taxpayer's Iowa individual income tax return for the year of the loss. However, the burden of proof is on the taxpayer to show that an alternate method of allocation is equitable.

Nonbusiness deductions included in the itemized deductions paid during the year of the net operating loss may be used to increase the NOL to the extent of nonbusiness income which is reported to Iowa in computation of the net operating loss. In most instances of net operating losses for nonresidents, no itemized deductions will be allowed in computing the net operating loss deduction. This is because most nonresidents will have no nonbusiness income reported to Iowa. Business deductions included in the federal itemized deductions may be used to increase the net operating loss deduction to the extent the deductions pertain to a business, trade, occupation or profession conducted in Iowa.

EXAMPLE A. A nonresident taxpayer had the following all source income and Iowa source income for 1982:

Category	All Source Income	Iowa Source Income
Wages	$20,000	$20,000
Interest	5,000	0
Rental income	5,000	5,000
Business loss	(50,000)	(10,000)
Iowa net income (loss)	($20,000)	$15,000

The nonresident taxpayer did not have an Iowa net operating loss available for carryback/carryforward for Iowa income tax purposes because the taxpayer's Iowa source income was not negative. The taxpayer's all source loss of ($20,000) does not qualify for carryback/carryforward on the Iowa return. However, since the taxpayer's all source income is negative, the taxpayer will not have an Iowa income tax liability for the year of the all source loss.

EXAMPLE B. A nonresident taxpayer received a federal refund of $1,000 in 1983. The refund was from the taxpayer's 1981 federal return where the taxpayer's Iowa income was 20% of the total income. $2,000 of federal income tax was withheld from the taxpayer's Iowa wages in 1982. The taxpayer had $10,000 in itemized deductions in 1982. However, the taxpayer had no Iowa nonbusiness income in 1982. In addition, no Iowa business deductions were included in the itemized deductions available on the federal return. The individual had the following all source income and Iowa source income in 1982:

Category	All Source Income	Iowa Source Income
Wages	$60,000	$10,000
Interest	3,000	0
Rental income	5,000	5,000
Farm income loss	(30,000)	(30,000)
Capital gain	2,000	2,000
Total incomes	$40,000	($13,000)

The taxpayer's Iowa source loss of ($13,000) was decreased by $200 of the federal refund since 20% of the refund was considered to be from Iowa income. The loss was decreased by $3,000 which was the capital gain deduction of the Iowa source asset sold in 1982. The loss was increased by the federal income tax withheld of $2,000 from Iowa wages. Because there is no Iowa source nonbusiness income nor Iowa source business deductions, the taxpayer's itemized deductions will not affect the net operating loss deduction.

Shown below is a recap of the net operating loss deduction for the nonresident taxpayer.

Iowa source net loss	($13,000)
Iowa portion of federal refund	200
Federal tax withheld on Iowa wages	(2,000)
Capital gain deduction	3,000
Total	($11,800)

The taxpayer's net operating loss deduction available for carryback/carryforward to another tax year is ($11,800).

After all adjustments are made to the Iowa net operating loss to compute the net operating loss deduction available for carryback/carryforward, the NOL deduction is applied to the carryback/carryforward tax year as described in paragraph *"a"* and paragraph *"b"* below:

a. Application of net operating losses to tax years beginning prior to January 1, 1982. In cases where a net operating loss deduction for a nonresident or part-year resident for a tax year beginning on

or after January 1, 1982, is applied to a tax year beginning prior to January 1, 1982, the net operating loss deduction is applied to the taxable income for the carryback/carryforward year unless the NOL deduction is greater than the taxable income. If the NOL deduction is greater than the taxable income, the taxable income is increased by any Iowa source capital loss or any Iowa source capital gain deduction before the NOL deduction is applied against the taxable income.

EXAMPLE 1. A nonresident taxpayer has an Iowa net operating loss deduction of ($15,000) from the taxpayer's 1982 Iowa return. The taxpayer is carrying the NOL deduction back to 1979 where taxpayer's Iowa taxable income was $14,000. The taxpayer had a net capital loss of $3,000 in 1979. Because the taxpayer's 1979 taxable income of $14,000 was $1,000 less than the NOL deduction, the taxable income was increased by $1,000 of the net capital loss so there would be no carryover of the NOL to 1980. However, since the NOL deduction erased all the taxable income for 1979, the taxpayer would be granted a refund of all the Iowa income tax paid for the carryback year of 1979, plus applicable interest.

b. Application of net operating losses to tax years beginning on or after January 1, 1982. In situations where a net operating loss of a nonresident or part-year resident for a tax year beginning on or after January 1, 1982, is carried back/carried forward for application to a tax year beginning on or after January 1, 1982, the net operating loss deduction is applied to the Iowa source income of the taxpayer for the carryback/carryforward year. The Iowa source income is the income on line 25 of Section B of Schedule IA-126 for the 1982 and 1983 Iowa returns and line 26 of Section B of Schedule IA-126 for the 1984 Iowa return and the incomes on similar corresponding lines of Section B of Schedule IA-126 for tax years after 1984. In situations where the net operating loss deductions are larger than the Iowa source incomes, the Iowa source incomes are increased by any Iowa source capital gains or capital losses that are applicable, not to exceed the NOL deduction.

The Iowa source net income after reduction by the NOL deduction is divided by the all source income for the taxpayer. The resulting percentage is the adjusted Iowa income percentage. This percentage is subtracted from 100 percent to arrive at the revised nonresident/part-year resident credit for the taxpayer. The taxpayer's overpayment as a result of the net operating loss is the amount by which the revised nonresident/part-year credit exceeds the nonresident/part-year credit prior to application of the net operating loss deduction.

EXAMPLE 1. A nonresident taxpayer had a net operating loss deduction of $11,800 for the 1996 tax year. When the 1996 Iowa return was filed, the taxpayer elected to carry the loss forward to the 1997 tax year. The taxpayer's all source net income and Iowa source net income for 1997 were as shown below. The net operating loss carryforward from 1996 is deducted only from the Iowa source income for 1997:

Category	All Source Income	Iowa Source Income
Wages	$ 60,000	$ 20,000
Interest	3,000	0
Rental income	10,000	3,000
Farm income	25,000	25,000
Capital gain	2,000	2,000
Net operating loss carryforward	—	(11,800)
Iowa net income	$100,000	$ 38,200

The Iowa source income of $38,200 after reduction by the NOL carryforward is divided by the all source income of $100,000 which results in an Iowa income percentage of 38.2. This percentage is subtracted from 100 percent to arrive at the nonresident/part-year resident credit percentage of 61.8. When the tax after credit amount of $7,364 is multiplied by the nonresident/part-year credit percentage of 61.8, this results in a credit of $4,551. This credit is $869 greater than the nonresident/part-year credit of $3,682 would have been for 1997 without application of the net operating loss deduction which was carried forward from 1996.

40.18(9) *Net operating loss carryback for a taxpayer engaged in the business of farming.* Notwithstanding the net operating loss carryback periods described in subrule 40.18(3), a taxpayer who is engaged in the trade or business of farming as defined in Section 263A(e)(4) of the Internal Revenue Code and has a loss from farming as defined in Section 172(b)(1)(F) of the Internal Revenue Code for a tax year beginning on or after January 1, 1998, this loss from farming is a net operating loss which the taxpayer may carry back five taxable years prior to the year of the loss. Therefore, if a taxpayer has a net operating loss from the trade or business of farming for the 1998 tax year, the net operating loss from farming can be carried back to the taxpayer's 1993 Iowa return and can be applied to the income shown on that return. The farming loss is the lesser of (1) the amount that would be the net operating loss for the tax year if only income and deductions from the farming business were taken into account, or (2) the amount of the taxpayer's net operating loss for the tax year. Thus, if a taxpayer has a $10,000 loss from a grain farming business and the taxpayer had wages in the tax year of $7,000, the taxpayer's loss for the year is only $3,000. Therefore, the taxpayer has a net operating loss from farming of $3,000 that may be carried back five years.

However, if a taxpayer has a net operating loss from the trade or business of farming for a taxable year beginning in 1998 or for a taxable year after 1998 and makes a valid election for federal income tax purposes to carry back the net operating loss two years, or three years if the loss was in a presidentially declared disaster area or related to a casualty or theft loss, the net operating loss must be carried back two years or three years for Iowa income tax purposes. A copy of the federal election made under Section 172(i)(3) for the two-year or three-year carryback in lieu of the five-year carryback may be attached to the Iowa return or the amended Iowa return to show why the carryback was two years or three years instead of five years.

This rule is intended to implement Iowa Code sections 422.5 and 422.7 and Iowa Code Supplement section 422.9(3).

701—40.19(422) Casualty losses. Casualty losses may be treated in the same manner as net operating losses and may be carried back three years and forward seven years in the event said casualty losses exceed income in the loss year.

This rule is intended to implement Iowa Code section 422.7.

701—40.20(422) Adjustments to prior years. When Iowa requests for refunds are filed, they shall be allowed only if filed within three years after the tax payment upon which a refund or credit became due, or one year after the tax payment was made, whichever time is the later. Even though a refund may be barred by the statute of limitations, a loss shall be carried back and applied against income on a previous year to determine the correct amount of loss carryforward.

This rule is intended to implement Iowa Code section 422.73.

701—40.21(422) Additional deduction for wages paid or accrued for work done in Iowa by certain individuals. For tax years beginning on or after January 1, 1984, but before January 1, 1989, a taxpayer who operates a business which is considered to be a small business as defined in subrule 40.21(2) is allowed an additional deduction for 50 percent of the first 12 months of wages paid or accrued during the tax years for work done in Iowa by employees first hired on or after January 1, 1984, or after July 1, 1984, where the taxpayer first qualifies as a small business under the expanded definition of a small business effective July 1, 1984, and meets one of the following criteria.

A handicapped individual domiciled in this state at the time of hiring.

An individual domiciled in this state at the time of hiring who meets any of the following conditions:

1. Has been convicted of a felony in this or any other state or the District of Columbia.
2. Is on parole pursuant to Iowa Code chapter 906.
3. Is on probation pursuant to Iowa Code chapter 907 for an offense other than a simple misdemeanor.
4. Is in a work release program pursuant to Iowa Code chapter 247A.

An individual, whether or not domiciled in this state at the time of the hiring, who is on parole or probation and to whom the interstate probation and parole compact under Iowa Code section 913.40 applies.

For tax years beginning on or after January 1, 1989, the additional deduction for wages paid or accrued for work done in Iowa by certain individuals is 65 percent of the wages paid for the first 12 months of employment of the individuals, not to exceed $20,000 per individual. Individuals must meet the same criteria to qualify their employers for this deduction for tax years beginning on or after January 1, 1989, as for tax years beginning before January 1, 1989.

For tax years ending after July 1, 1990, a taxpayer who operates a business which does not qualify as a small business specified in subrule 40.21(2) may claim an additional deduction for wages paid or accrued for work done in Iowa by certain convicted felons provided the felons are described in the four numbered paragraphs above and the following unnumbered paragraph and provided the felons are first hired on or after July 1, 1990. The additional deduction is 65 percent not to exceed $20,000 for the first 12 months of wages paid for work done in Iowa.

The qualifications mentioned in subrules 40.21(1), 40.21(4), 40.21(5) and 40.21(6) and in subrule 40.21(3), paragraphs *"f"* and *"g,"* apply to the additional deduction for work done in Iowa by a convicted felon in situations where the taxpayer is not a small business as well as in situations where the taxpayer is a small business.

The additional deduction applies to any individual hired on or after July 1, 2001, whether or not domiciled in Iowa at the time of hiring, who is on parole or probation and to whom either the interstate probation and parole compact under Iowa Code section 907A.1 or the compact for adult offenders under Iowa Code chapter 907B applies. The amount of additional deduction for hiring this individual is equal to 65 percent of the wages paid, but the additional deduction is not to exceed $20,000 for the first 12 months of wages paid for work done in Iowa.

40.21(1) The additional deduction shall not be allowed for wages paid to an individual who was hired to replace an individual whose employment was terminated within the 12-month period preceding the date of first employment. However, if the individual being replaced left employment voluntarily without good cause attributable to the employer or if the individual was discharged for misconduct in connection with the individual's employment as determined by the department of workforce development, the additional deduction shall be allowed.

The determination of whether an individual left employment voluntarily without good cause attributable to the employer or if the individual was discharged for misconduct is a factual determination which must be made on a case-by-case basis.

40.21(2) The term "small business" means a business entity organized for profit including but not limited to an individual proprietorship, partnership, joint venture, association or cooperative. It includes the operation of a farm, but not the practice of a profession. The following conditions apply to a business entity which is a small business for purposes of the additional deduction for wages:

a. The small business shall not have had more than 20 full-time equivalent employee positions during each of the 26 consecutive weeks within the 52-week period immediately preceding the date on which an individual for whom an additional deduction for wages is taken was hired. Full-time equivalent position means any of the following:

1. An employment position requiring an average work week of 40 or more hours;
2. An employment position for which compensation is paid on a salaried full-time basis without regard to hours worked; or
3. An aggregation of any number of part-time positions which equal one full-time position. For purposes of this subrule each part-time position shall be categorized with regard to the average number of hours worked each week as a one-quarter, half, three-quarter, or full-time position, as set forth in the following table:

Average Number of Weekly Hours	Category
More than 0 but less than 15	¼
15 or more but less than 25	½
25 or more but less than 35	¾
35 or more	1 (full-time)

b. The small business shall not have more than $1 million in annual gross revenues, or after July 1, 1984, $3 million in annual gross revenues or as the average of the three preceding tax years. "Annual gross revenues" means total sales, before deducting returns and allowances but after deducting corrections and trade discounts, sales taxes and excise taxes based on sales, as determined in accordance with generally accepted accounting principles.

c. The small business shall not be an affiliate or subsidiary of a business which is dominant in its field of operation. "Dominant in its field of operation" means having more than 20 full-time equivalent employees and more than $1 million of annual gross revenues, or after July 1, 1984, $3 million of annual gross revenues or as the average of the three preceding tax years. "Affiliate or subsidiary of a business dominant in its field of operations" means a business which is at least 20 percent owned by a business dominant in its field of operation, or by partners, officers, directors, majority stockholders, or their equivalent, of a business dominant in that field of operation.

d. "Operation of a farm" means the cultivation of land for the production of agricultural crops, the raising of poultry, the production of eggs, the production of milk, the production of fruit or other horticultural crops, grazing or the production of livestock. Operation of a farm shall not include the production of timber, forest products, nursery products, or sod and operation of a farm shall not include a contract where a processor or distributor of farm products or supplies provides spraying, harvesting or other farm services.

e. "The practice of a profession" means a vocation requiring specialized knowledge and preparation including but not limited to the following: medicine and surgery, podiatry, osteopathy, osteopathic medicine and surgery, psychology, psychiatry, chiropractic, nursing, dentistry, dental hygiene, optometry, speech pathology, audiology, pharmacy, physical therapy, occupational therapy, mortuary science, law, architecture, engineering and surveying, and accounting.

40.21(3) Definitions.

a. The term *"handicapped person"* means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

The term handicapped does not include any person who is an alcoholic or drug abuser whose current use of alcohol or drugs prevents the person from performing the duties of employment or whose employment, by reason of current use of alcohol or drugs, would constitute a direct threat to the property or the safety of others.

b. The term *"physical or mental impairment"* means any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin and endocrine; or any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

c. The term *"major life activities"* means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

d. The term *"has a record of such impairment"* means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

e. The term *"is regarded as having such an impairment"* means:

1. Has a physical or mental impairment that does not substantially limit major life activities but that is perceived as constituting such a limitation;

2. Has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or

3. Has none of the impairments defined as physical or mental impairments, but is perceived as having such an impairment.

f. The term *"successfully completing a probationary period"* includes those instances where the employee quits without good cause attributable to the employer during the probationary period or was discharged for misconduct during the probationary period.

g. The term *"probationary period"* means the period of probation for newly hired employees, if the employer has a written probationary policy. If the employer has no written probationary policy for newly hired employees, the probationary period shall be considered to be six months from the date of hire.

40.21(4) If a newly hired employee has been certified as either a vocational rehabilitation referral or an economically disadvantaged ex-convict for purposes of qualification for the work opportunity tax credit under Section 51 of the Internal Revenue Code, that employee shall be considered to have met the qualifications for the additional wage deduction.

A vocational rehabilitation referral is any individual certified by a state employment agency as having a physical or mental disability which, for the individual constitutes or results in a substantial handicap to employment. In addition, the individual must have been referred to the employer after completion or while receiving rehabilitation services pursuant to either a state or federal approved vocational rehabilitation program.

For all other newly hired employees, the employer has the burden of proof to show that the employees meet the qualifications for the additional wage deduction.

40.21(5) The taxpayer shall include a schedule with the filing of its tax return showing the name, address, social security number, date of hiring and wages paid of each employee for which the taxpayer claims the additional deduction for wages.

40.21(6) If the employee for which an additional deduction for wages was allowed fails to successfully complete a probationary period and the taxpayer has already filed an Iowa individual income tax return taking the additional deduction for wages, the taxpayer shall file an amended return adding back the additional deduction for wages. The amended return shall state the name and social security number of the employee who failed to successfully complete a probationary period.

This rule is intended to implement Iowa Code section 422.7 as amended by 2001 Iowa Acts, House Files 287 and 759.

[**ARC 7761B**, IAB 5/6/09, effective 6/10/09]

701—40.22(422) Disability income exclusion.

40.22(1) Effective for tax years beginning on or after January 1, 1984, a taxpayer who is permanently and totally disabled and has not attained age 65 by the end of the tax year or reached mandatory retirement age can exclude a maximum of $100 per week of payments received in lieu of wages. In order for the payments to qualify for the exclusion, the payments must be made under a plan providing payment of such amounts to an employee for a period during which the employee is absent from work on account of permanent and total disability.

40.22(2) In the case of a married couple where both spouses meet the qualifications for the disability exclusion, each spouse may exclude $5,200 of income received on account of disability.

40.22(3) There is a reduction in the exclusion, dollar for dollar, to the extent that a taxpayer's federal adjusted gross income (determined without this exclusion and without the deduction for the two-earner married couple) exceeds $15,000. In the case of a married couple, both spouses' incomes must be considered for purposes of determining if the disability income exclusion is to be reduced for income that exceeds $15,000. The taxpayers' disability income exclusion is eliminated when the taxpayers' federal adjusted gross income is equal to or exceeds $20,200. The deduction of the taxpayers' disability income exclusion because the taxpayers' federal adjusted gross income is greater than $15,000 is illustrated in the following example:

A married couple is filing their 1984 Iowa return. The husband retired during the year and received $8,000 in disability income during the 40-week period in 1984 that he was retired. The husband's other income in 1984 was $2,500 and the wife's income was $7,500.

Of the $8,000 in disability payments received by the husband in the 40-week period he was retired in 1984, only $4,000 is eligible for the exclusion. This is because the maximum amount that can be excluded on a weekly basis as a result of the disability exclusion is $100.

However, the $4,000 that qualifies for the exclusion must be reduced to the extent that the taxpayer's federal adjusted gross income exceeds $15,000. In this example, the taxpayer's federal adjusted gross income is $18,000, which exceeds $15,000 by $3,000. Therefore, the amount eligible for exclusion of $4,000 must be reduced by $3,000. This gives the taxpayers an exclusion of $1,000.

40.22(4) For purposes of the disability income exclusion, "permanent and total disability" means the individual is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which (a) can be expected to last for a continuous period of 12 months or more or (b) can be expected to result in death. A certificate from a qualified physician must be attached to the individual's tax return attesting to the taxpayer's permanent and total disability as of the date the individual claims to have retired on disability. The certificate must include the name and address of the physician and contain an acknowledgment that the certificate will be used by the taxpayer to claim the exclusion. In an instance where an individual has been certified as permanently and totally disabled by the Veterans Administration, Form 6004 may be attached to the return instead of the physician's certificate. Form 6004 must be signed by a physician on the VA disability rating board.

40.22(5) Mandatory retirement age is the age at which the taxpayer would have been required to retire under the employer's retirement program.

40.22(6) The disability income exclusion is not applicable to federal income tax for tax years beginning after 1983. There are many revenue rulings, court cases and other provisions which were relevant to the disability income exclusion for the tax periods when the exclusion was available on federal returns. These provisions, court cases and revenue rulings concerning the disability income exclusion are equally applicable to the disability income exclusion on Iowa returns for tax years beginning on or after January 1, 1984.

This rule is intended to implement Iowa Code section 422.7.

701—40.23(422) Social security benefits. For tax years beginning on or after January 1, 1984, but before January 1, 2014, social security benefits received are taxable on the Iowa return. Although Tier 1 railroad retirement benefits were taxed similarly as social security benefits for federal income tax purposes beginning on or after January 1, 1984, these benefits are not subject to Iowa income tax. 45 U.S.C. Section 231m prohibits taxation of railroad retirement benefits by the states.

The following subrules specify how social security benefits are taxed for Iowa individual income tax purposes for tax years beginning on or after January 1, 1984, but prior to January 1, 1994; for tax years beginning on or after January 1, 1994, but prior to January 1, 2007; and for tax years beginning on or after January 1, 2007, but prior to January 1, 2014:

40.23(1) *Taxation of social security benefits for tax years beginning on or after January 1, 1984, but prior to January 1, 1994.* For tax years beginning on or after January 1, 1984, but prior to January 1, 1994, social security benefits are taxable on the Iowa return to the same extent as the benefits are taxable for federal income tax purposes. When both spouses of a married couple receive social security benefits and file a joint federal income tax return but separate returns or separately on the combined return form, the taxable portion of the benefits must be allocated between the spouses. The following formula should be used to compute the amount of social security benefits to be reported by each spouse on the Iowa return:

$$\text{Taxable Social Security Benefits on the Federal Return} \times \frac{\text{Total Social Security Benefit Received by Husband (or Wife)}}{\text{Total Social Security Benefits Received by Both Spouses}}$$

The example shown below illustrates how taxable social security benefits are allocated between spouses:

A married couple filed a joint federal income tax return for 1984. They filed separately on the combined return form for Iowa income tax purposes. During the tax year the husband received $6,000 in social security benefits and the wife received $3,000 in social security benefits. $2,000 of the social security benefits was taxable on the federal return.

The $2,000 in taxable social security benefits is allocated to the spouses on the following basis:

Husband

$$\$2{,}000 \times \frac{\$6{,}000}{\$9{,}000} = \$1{,}333.40$$

Wife

$$\$2{,}000 \times \frac{\$3{,}000}{\$9{,}000} = \$666.60$$

In situations where taxpayers have received both social security benefits and Tier 1 railroad retirement benefits and are taxable on a portion of those benefits, the formula which follows should be used to determine the social security benefits to be included in net income:

$$\text{Taxable Social Security Benefits and Railroad Retirement Benefits on Federal Return} \times \frac{\text{Total Social Security Benefit Received}}{\text{Total Social Security Benefits and Railroad Retirement Benefits Received}}$$

40.23(2) *Taxation of social security benefits for tax years beginning on or after January 1, 1994, but prior to January 1, 2007.* For tax years beginning on or after January 1, 1994, but prior to January 1, 2007, although up to 85 percent of social security benefits received may be taxable for federal income tax purposes, no more than 50 percent of social security benefits will be taxable for state individual income tax purposes. Thus, in the case of Iowa income tax returns for 1994 through 2006, social security benefits will be taxed as the benefits were taxed from 1984 through 1993 as described in subrule 40.23(1).

The amount of social security benefits that is subject to tax is the lesser of one-half of the annual benefits received in the tax year or one-half of the taxpayer's provisional income over a specified base amount. The provisional income is the taxpayer's modified adjusted gross income plus one-half of the social security benefits and one-half of the railroad retirement benefits received. Although railroad benefits are not taxable, one-half of the railroad retirement benefits received may be used to determine the amount of social security benefits that is taxable for state income tax purposes. Modified adjusted gross income is the taxpayer's federal adjusted gross income, plus interest that is tax-exempt on the federal return, plus any of the following incomes:

1. Savings bond proceeds used to pay expenses of higher education excluded from income under Section 135 of the Internal Revenue Code.
2. Foreign source income excluded from income under Section 911 of the Internal Revenue Code.
3. Income from Guam, American Samoa, and the Northern Mariana Islands excluded under section 931 of the Internal Revenue Code.
4. Income from Puerto Rico excluded under Section 933 of the Internal Revenue Code.

A taxpayer's base amount is: *(a)* $32,000 if married and a joint federal return was filed, *(b)* $0 if married and separate federal returns were filed by the spouses and *(c)* $25,000 for individuals who filed federal returns and used a filing status other than noted in *(a)* and *(b)*.

The IA 1040 booklet and instructions for 1994 through 2006 will include a worksheet to compute the amount of social security benefits that is taxable for Iowa income tax purposes. An example of the social security worksheet follows. Similar worksheets will be used for computing the amount of social security benefits that is taxable for years 1995 through 2006. An example of the social security worksheet follows:

1. Enter amount(s) from box 5 of all of Form(s) SSA-1099. If a joint return was filed, enter totals from box 5 of Form(s) SSA-1099 for both spouses. Do not include railroad retirement benefits from RRB-1099 here. See line 3.	1. _____
2. Divide line 1 amount above by 2.	2. _____
*3. Add amounts of the following incomes from Form 1040: wages, taxable interest income, dividend income, taxable state and local income tax refunds, alimony, business income or loss, capital gain or loss, capital gain distributions, other gains, taxable IRA distributions, taxable pensions and annuities, incomes from Schedule E, farm income or loss, unemployment compensation, other income and 1/2 of railroad retirement benefits from RRB 1099.	3. _____
4. Enter amount from Form 1040, line 8b for interest that is federally tax-exempt.	4. _____
5. Add lines 2, 3 and 4.	5. _____
6. Enter total adjustment to income from Form 1040.	6. _____
7. Subtract line 6 from line 5.	7. _____
8. Enter on line 8 one of the following amounts based on the filing status used on Form 1040: Single, Head of Household, or Qualifying Widow(er), enter $25,000. Married filing jointly, enter $32,000. Married filing separately, enter $0 ($25,000 if you did not live with spouse any time in 1994).	8. _____
9. Subtract line 8 from line 7. If zero or less enter 0. If line 9 is zero, none of the social security benefits are taxable. If line 9 is more than zero, go to line 10.	9. _____
10. Divide line 9 amount above by 2.	10. _____
11. Taxable social security benefits enter smaller of line 2 or line 10 here and on line 14 IA 1040.	11. _____

*If applicable, include on line 3 the following incomes excluded from federal adjusted gross income: foreign earned income, income excluded by residents of Puerto Rico, American Samoa, and Guam and proceeds from savings bonds used for higher education.

Married taxpayers who filed a joint federal return and are filing separate Iowa returns or separately on the combined return form can allocate taxable social security benefits between them with the following formula.

$$\text{Taxable Social Security Benefits From Worksheet} \times \frac{\text{Total Social Security Benefit Received by Husband (or Wife)}}{\text{Total Social Security Benefits Received by Both Spouses}}$$

40.23(3) *Taxation of social security benefits for tax years beginning on or after January 1, 2007, but prior to January 1, 2014.* For tax years beginning on or after January 1, 2007, but prior to January 1, 2014, the amount of social security benefits subject to Iowa income tax will be computed as described in subrule 40.23(2), but will be further reduced by the following percentages:

Calendar years 2007 and 2008	32%
Calendar year 2009	43%
Calendar year 2010	55%
Calendar year 2011	67%
Calendar year 2012	77%
Calendar year 2013	89%

The Iowa individual income tax booklet and instructions for 2007 through 2013 will include a worksheet to compute the amount of social security benefits that is taxable for Iowa income tax purposes. An example of the social security worksheet follows:

1. Enter amount(s) from box 5 of Form(s) SSA-1099. If a joint return was filed, enter totals from box 5 of Form(s) SSA-1099 for both spouses. Do not include railroad retirement benefits from RRB-1099 here. See line 3.	1. _____
2. Divide line 1 amount above by 2.	2. _____
*3. Add amounts of the following incomes from Form 1040: wages, taxable interest income, dividend income, taxable state and local income tax refunds, alimony, business income or loss, capital gain or loss, capital gain distributions, other gains, taxable IRA distributions, taxable pensions and annuities, incomes from Schedule E, farm income or loss, unemployment compensation, other income and 1/2 of railroad retirement benefits from RRB 1099.	3. _____
4. Enter amount from Form 1040, line 8b for interest that is federally tax-exempt.	4. _____
5. Add lines 2, 3 and 4.	5. _____
6. Enter total adjustment to income from Form 1040.	6. _____
7. Subtract line 6 from line 5.	7. _____
8. Enter on line 8 one of the following amounts based on the filing status used on Form 1040: Single, Head of Household, or Qualifying Widow(er), enter $25,000. Married filing jointly, enter $32,000. Married filing separately, enter $0 ($25,000 if you did not live with spouse anytime during the year).	8. _____
9. Subtract line 8 from line 7. If zero or less enter 0. If line 9 is zero, none of the social security benefits are taxable. If line 9 is more than zero, go to line 10.	9. _____
10. Divide line 9 amount above by 2.	10. _____
11. Taxable social security benefits before phase-out exclusion. Enter smaller of line 2 or line 10.	11. _____
12. Multiply line 11 by applicable exclusion percentage.	12. _____
13. Taxable social security benefits. Subtract line 12 from line 11.	13. _____

*If applicable, include on line 3 the following incomes excluded from federal adjusted gross income: foreign earned income, income excluded by residents of Puerto Rico, American Samoa, and Guam and proceeds from savings bonds used for higher education and employer-provided adoption benefits.

Married taxpayers who filed a joint federal return and are filing separate Iowa returns or separately on the combined return form can allocate taxable social security benefits between them with the following formula.

$$\text{Taxable Social Security Benefits From Worksheet} \times \frac{\text{Total Social Security Benefit Received by Spouse 1 (or Spouse 2)}}{\text{Total Social Security Benefits Received by Both Spouses}}$$

The amount on line 12 of this worksheet is the phase-out exclusion of social security benefits which must be included in net income in determining whether an Iowa return must be filed in accordance with rules 701—39.1(422) and 701—39.5(422), and this amount must also be included in net income in calculating the special tax computation in accordance with rule 701—39.15(422).

40.23(4) *Taxation of social security benefits for tax years beginning on or after January 1, 2014.* For tax years beginning on or after January 1, 2014, no social security benefits are taxable on the Iowa return. However, the 100 percent phase-out exclusion of social security benefits must still be included in net income in determining whether an Iowa return must be filed in accordance with rules 701—39.1(422) and

701—39.5(422), and the 100 percent phase-out exclusion of social security benefits must also be included in net income in calculating the special tax computation in accordance with rule 701—39.15(422).

This rule is intended to implement Iowa Code section 422.7 as amended by 2006 Iowa Acts, Senate File 2408.

701—40.24(99E) Lottery prizes. Prizes awarded under the Iowa Lottery Act are Iowa earned income. Therefore, individuals who win lottery prizes are subject to Iowa income tax in the aggregate amount of prizes received in the tax year, even if the individuals were not residents of Iowa at the time they received the prizes.

This rule is intended to implement Iowa Code section 99E.19.

701—40.25(422) Certain unemployment benefits received in 1979. Rescinded IAB 11/24/04, effective 12/29/04.

701—40.26(422) Contributions to the judicial retirement system. Rescinded IAB 11/24/04, effective 12/29/04.

701—40.27(422) Incomes from distressed sales of qualifying taxpayers. For tax years beginning on or after January 1, 1986, taxpayers with gains from sales, exchanges, or transfers of property must exclude those gains from net income, if the gains are considered to be distressed sale transactions.

40.27(1) *Qualifications that must be met for transactions to be considered distressed sales.* There are a number of qualifications that must be met before a transaction can be considered to be a distressed sale. The transaction must involve forfeiture of an installment real estate contract, the transfer of real or personal property securing a debt to a creditor in cancellation of that debt, or from the sale or exchange of property as a result of actual notice of foreclosure. The following three additional qualifications need to have been met.

a. The forfeiture, transfer, or sale or exchange was done for the purpose of establishing a positive cash flow.

b. Immediately before the forfeiture, transfer, or sale or exchange, the taxpayer's debt-to-asset ratio exceeded 90 percent as computed under generally accepted accounting principles.

c. The taxpayer's net worth at the end of the tax year was less than $75,000.

In determining the taxpayer's debt-to-asset ratio immediately before the forfeiture, transfer, or sale or exchange and at the end of the tax year, the taxpayer must include any asset transferred within 120 days prior to the transaction or within 120 days prior to the end of the tax year without adequate and full consideration in money or money's worth.

Proof of forfeiture of the installment real estate contract, proof of transfer of property to a creditor in cancellation of a debt, or a copy of the notice of foreclosure constitutes documentation of the distressed sale and must be made a part of the return. Balance sheets showing the taxpayer's debt-to-asset ratio immediately before the distressed sale transaction and the taxpayer's net worth at the end of the tax year must also be included with the income tax return. The balance sheets supporting the debt-to-asset ratio and the net worth must list the taxpayer's personal assets and liabilities as well as the assets and liabilities of the taxpayer's farm or other business.

For purposes of this provision, in the case of married taxpayers, except in the instance when the husband and wife live apart at all times during the tax year, the assets and liabilities of both spouses must be considered in determining the taxpayers' net worth or the taxpayers' debt-to-asset ratio.

40.27(2) *Losses from distressed sale transactions of qualifying taxpayers.* Losses from distressed sale transactions meeting the qualifications described above were disallowed prior to the time that the provision for disallowing these losses was repealed in the 1990 session of the General Assembly. Taxpayers whose Iowa income tax liabilities were increased because of disallowance of losses from distressed sales transactions may file refund claims with the department to get refunds of the taxes paid due to disallowance of the losses. Refund claims will be honored by the department to the extent that

the taxpayers provide verification of the distressed sale losses and the claims are filed within the statute of limitations for refund given in Iowa Code subsection 422.73(2).

This rule is intended to implement Iowa Code section 422.7.

701—40.28(422) Losses from passive farming activities. Rescinded IAB 2/18/04, effective 3/24/04.

701—40.29(422) Intangible drilling costs. For tax years beginning on or after January 1, 1986, but before January 1, 1987, intangible drilling and development costs which pertain to any well for the production of oil, gas, or geothermal energy, and which are incurred after the commencement of the installation of the production casing for the well, are not allowed as an expense in the tax year when the costs were paid or incurred and must be added to net income. Instead of expensing the intangible drilling and development costs which are incurred after the commencement of the installation of the production casing for a well, the expenses must be amortized over a 26-month period, beginning in the month in which the costs are paid or incurred if the costs were incurred for a well which is located in the United States, the District of Columbia, and those continental shelf areas which are adjacent to United States territorial waters and over which the United States has exclusive rights with respect to the exploration and exploitation of natural resources as provided in Section 638 of the Internal Revenue Code.

In the case of intangible drilling and development costs which are incurred for oil or gas wells outside the United States, those costs must be recovered over a ten-year straight-line amortization period beginning in the year the costs are paid or incurred. However, in lieu of amortization of the costs, the taxpayer may elect to add these costs to the basis of the property for cost depletion purposes.

For tax years beginning on or after January 1, 1987, the intangible drilling costs, which are an addition to income subject to amortization, are the intangible drilling costs described in Section 57(a)(2) of the Internal Revenue Code. These intangible drilling costs are an item of tax preference for federal minimum tax purposes for tax years beginning after December 31, 1986.

This rule is intended to implement Iowa Code section 422.7.

701—40.30(422) Percentage depletion. For tax years beginning on or after January 1, 1987, the percentage depletion that is an addition to net income is the depletion described in Section 57(a)(1) of the Internal Revenue Code only to the extent the depletion applies to an oil, gas, or geothermal well. This depletion is an item of tax preference for federal minimum tax purposes for tax years beginning after December 31, 1986.

This rule is intended to implement Iowa Code section 422.7.

[**ARC 7761B**, IAB 5/6/09, effective 6/10/09]

701—40.31(422) Away-from-home expenses of state legislators. For tax years beginning on or after January 1, 1987, state legislators whose personal residences in their legislative districts are more than 50 miles from the state capitol may claim the same deductions for away-from-home expenses as are allowed on their federal income tax returns under Section 162(h)(1)(B) of the Internal Revenue Code. These individuals may claim deductions for meals and lodging per "legislative day" in the amount of per diem allowance for federal employees in effect for the tax year. The portion of this per diem allowance which is equal to the daily expense allowance authorized for state legislators in Iowa Code section 2.10 may be claimed as an adjustment to income. The balance of the per diem allowance for federal employees must be allocated between lodging expenses and meal expenses and is deductible as a miscellaneous itemized deduction. However, only 50 percent of the amount attributable to meal expenses may be deducted for tax years beginning on or after January 1, 1994.

State legislators whose personal residences in their legislative districts are 50 miles or less from the state capitol may claim a deduction for meals and lodging of $50 per "legislative day." However, in lieu of either of the deduction methods previously described in this rule, any state legislator may elect to itemize adjustments to income for amounts incurred for meals and lodging for the "legislative days" of the state legislator.

This rule is intended to implement Iowa Code section 422.7.

[**ARC 7761B**, IAB 5/6/09, effective 6/10/09]

701—40.32(422) Interest and dividends from regulated investment companies which are exempt from federal income tax. For tax years beginning on or after January 1, 1987, interest and dividends from regulated investment companies which are exempt from federal income tax under the Internal Revenue Code are subject to Iowa income tax. See rule 701—40.52(422) for a discussion of the Iowa income tax exemption of some interest and dividends from regulated investment companies that invest in certain obligations of the state of Iowa and its political subdivisions the interest from which is exempt from Iowa income tax. To the extent that a loss on the sale or exchange of stock in a regulated investment company was disallowed on an individual's federal income tax return pursuant to Section 852(b)(4)(B) of the Internal Revenue Code because the taxpayer held the stock six months or less and because the regulated investment company had invested in federal tax-exempt securities, the loss is allowed for purposes of computation of net income.

This rule is intended to implement Iowa Code section 422.7.

701—40.33(422) Partial exclusion of pensions and annuities for retired and disabled public employees. Rescinded IAB 11/24/04, effective 12/29/04.

701—40.34(422) Exemption of restitution payments for persons of Japanese ancestry. For tax years beginning on or after January 1, 1988, restitution payments authorized by P.L. 100-383 to individuals of Japanese ancestry who were interned during World War II are exempt from Iowa income tax to the extent the payments are included in federal adjusted gross income. P.L. 100-383 provides for a payment of $20,000 for each qualifying individual who was alive on August 10, 1988. In cases where the qualifying individuals have died prior to the time that the restitution payments were received, the restitution payments received by the survivors of the interned individuals are also exempt from Iowa income tax.

This rule is intended to implement Iowa Code section 422.7.

701—40.35(422) Exemption of Agent Orange settlement proceeds received by disabled veterans or beneficiaries of disabled veterans. For tax years beginning on or after January 1, 1989, proceeds from settlement of a lawsuit against the manufacturer or distributor of a Vietnam herbicide received by a disabled veteran or the beneficiary of a disabled veteran for damages from exposure to the herbicide are exempt from Iowa income tax to the extent the proceeds are included in federal adjusted gross income. For purposes of this rule, Vietnam herbicide means a herbicide, defoliant, or other causative agent containing a dioxin, including, but not limited to, Agent Orange used in the Vietnam conflict beginning December 22, 1961, and ending May 7, 1975.

This rule is intended to implement Iowa Code section 422.7.

701—40.36(422) Exemption of interest earned on bonds issued to finance beginning farmer loan program. Interest earned on or after July 1, 1989, from bonds or notes issued by the agricultural development authority to finance the beginning farmer loan program is exempt from the state income tax.

This rule is intended to implement Iowa Code sections 175.17 and 422.7.

701—40.37(422) Exemption of interest from bonds issued by the Iowa comprehensive petroleum underground storage tank fund board. Interest received from bonds issued by the Iowa comprehensive petroleum underground storage tank fund board is exempt from state individual income tax. This is effective for interest received from these bonds on or after May 5, 1989, but before July 1, 2009.

This rule is intended to implement Iowa Code section 455G.6.

701—40.38(422) Capital gain deduction or exclusion for certain types of net capital gains. For tax years beginning on or after January 1, 1998, net capital gains from the sale of the assets of a business described in subrules 40.38(2) to 40.38(8) are excluded in the computation of net income for qualified individual taxpayers. This includes net capital gains from the sales of real property, sales of assets of a

business entity, sales of certain livestock of a business, sales of timber, liquidation of assets of certain corporations, and certain stock sales which are treated as acquisition of assets of a corporation. "Net capital gains" means capital gains net of capital losses because Iowa's starting point for computing net income is federal adjusted gross income. A business includes any activity engaged in by a person or caused to be engaged in by a person with the object of gain, benefit, or advantage, either direct or indirect. Subrule 40.38(1) describes the criteria for material participation which are required for the exclusion of certain capital gains related to the sale of real property and the sale of assets of business entities. Subrule 40.38(9) describes situations in which the capital gain deduction otherwise allowed is not allowed for purposes of computation of a net operating loss or for computation of the taxable income for a tax year to which a net operating loss is carried.

40.38(1) *Material participation in a business if the taxpayer has been involved in the operation of the business on a regular, continuous, and substantial basis for ten or more years at the time assets of the business are sold or exchanged.* If the taxpayer has regular, continuous and substantial involvement in the operations of a business which meets the criteria for material participation in an activity under Section 469(h) of the Internal Revenue Code and the federal tax regulations for material participation in 26 CFR §1.469-5 and §1.469-5T, for the ten years prior to the date of the sale or exchange of the assets of a business, the taxpayer shall be considered to have satisfied the material participation requirement for this subrule. In determining whether a particular taxpayer has material participation in a business, participation of the taxpayer's spouse in a business must also be taken into account. The spouse's participation in the business must be taken into account even if the spouse does not file a joint state return with the taxpayer or if the spouse has no ownership interest in the business. The activities of other family members, employees, or consultants are not attributed to the taxpayer to determine material participation.

a. Work done in connection with an activity shall not be treated as participation in the activity if such work is not of a type that is customarily done by an owner and one of the principal purposes for the performance of such work is to avoid the disallowance of any loss or credit from such activity.

b. Work done in an activity by an individual in the individual's capacity as an investor is not considered to be material participation in the business or activity unless the investor is directly involved in the day-to-day management or operations of the activity or business.

c. A taxpayer is most likely to have material participation in a business if that business is the taxpayer's principal business. However, for purposes of this subrule, it is possible for a taxpayer to have had material participation in more than one business in a tax year.

d. A highly relevant factor in material participation in a business is how regularly the taxpayer is present at the place where the principal operations of a business are conducted. In addition, a taxpayer is likely to have material participation in a business if the taxpayer performs all functions of the business. The fact that the taxpayer utilizes employees or contracts for services to perform daily functions in a business will not prevent the taxpayer from qualifying as materially participating in the business, but the services will not be attributed to the taxpayer.

e. Generally, an individual will be considered as materially participating in a tax year if the taxpayer satisfies or meets any of the following tests:

(1) The individual participates in the business for more than 500 hours in the taxable year.

EXAMPLE. Joe and Sam Smith are brothers who formed a computer software business in 2001 in Altoona, Iowa. In 2011, Joe spent approximately 550 hours selling software for the business and Sam spent about 600 hours developing new software programs for the business. Both Joe and Sam would be considered to have materially participated in the computer software business in 2011.

(2) The individual's participation in the business constitutes substantially all of the participation of all individuals in the business for the tax year.

EXAMPLE. Roger McKee is a teacher in a small town in southwest Iowa. He owns a truck with a snowplow blade. He contracts with some of his neighbors to plow driveways. He maintains and drives the truck. In the winter of 2011, there was little snow so Mr. McKee spent only 20 hours in 2011 clearing driveways. Roger McKee is deemed to have materially participated in the snowplowing business in 2011.

(3) The individual participates in the business for more than 100 hours in the tax year, and no other individual spends more time in the business activity than the taxpayer.

(4) The individual participates in two or more businesses, excluding rental businesses, in the tax year and participates for more than 500 hours in all of the businesses and more than 100 hours in each of the businesses, and the participation is not material participation within the meaning of one of the tests in subparagraphs 40.38(1)*"e"*(1) to (3) and (5) to (7). Thus, the taxpayer is regarded as materially participating in each of the businesses.

EXAMPLE. Frank Evans is a full-time CPA. He owns a restaurant and a record store. In 2011, Mr. Evans spent 400 hours working at the restaurant and 150 hours at the record store and other individuals spent more time in the business activity than he did. Mr. Evans is treated as a material participant in each of the businesses in 2011.

(5) An individual who has materially participated (determined with regard to subparagraphs 40.38(1)*"e"*(1) to (4)) in a business for five of the past ten years will be deemed a material participant in the current year.

EXAMPLE. Joe Bernard is the co-owner of a plumbing business. He retired in 2008 after 35 years in the business. Since Joe's retirement, he has retained his interest in the business. Joe is considered to be materially participating in the business for the years through 2013 or for the five years after the year of retirement. Thus, if the plumbing business is sold before the end of 2013, the sale will qualify for the Iowa capital gain deduction on Joe's 2013 Iowa return because he was considered to be a material participant in the business according to the federal rules for material participation.

(6) An individual who has materially participated in a personal service activity for at least three years will be treated as a material participant for life. A personal service activity involves the performance of personal services in the fields of health, law, engineering, architecture, accounting, actuarial science, performing arts, consulting or any other trade or business in which capital is not a material income-producing factor.

EXAMPLE. Gerald Williams is a retired attorney, but he retains an interest in the law firm he was involved in for over 40 years. Because the law firm is a personal service activity, Mr. Williams is considered to be a material participant in the law firm even after his retirement from the firm.

(7) An individual who participates in the business activity for more than 100 hours may be treated as materially participating in the activity if, based on all the facts and circumstances, the individual participates on a regular, continuous, and substantial basis. Management activities of a taxpayer are not considered for purposes of determining if there was material participation if either of the following applies: any person other than the taxpayer is compensated for management services, or any person provides more hours of management services than the taxpayer.

f. The following paragraphs provide clarification regarding the facts and circumstances test in subparagraph 40.38(1)*"e"*(7):

(1) A retired or disabled farmer is treated as materially participating in a farming activity for the current year if the farmer materially participated in the activity for five of the last eight years before the farmer's retirement or disability. That is, the farmer must have been subject to self-employment tax in five of the eight years before retirement or disability and had to have been either actively farming so the income was reported on Schedule F or materially participating in a crop-share activity for five of the last eight years prior to retirement or disability. The farmer must be receiving old-age benefits under Title II of the Social Security Act to be considered a retired farmer.

EXAMPLE. Fred Smith was 80 years old in 2011 when he sold 200 acres of farmland he had owned since 1951. Mr. Smith retired in 2001 when he began receiving old-age benefits under Title II of the Social Security Act. In the last eight years before retirement, Mr. Smith was paying self-employment tax on his farm income which was reported on Schedule F for each of those eight years. In the years before he sold the farmland, Mr. Smith was leasing the farmland on a cash-rent basis, whereby Mr. Smith would not be considered to be materially participating in the farming activity. Because Mr. Smith had material participation in the farmland in the eight years before retirement, Mr. Smith was considered to have met the material participation requirement, so the capital gain qualified for the Iowa capital gain deduction.

(2) A surviving spouse of a farmer is treated as materially participating in the farming activity for the current tax year if the farmer met the material participation requirements at the time of death and the spouse actively participates in the farming business activity. That is, the spouse participates in the making of management decisions relating to the farming activity or arranges for others to provide services (such as repairs, plowing, and planting). However, if the surviving spouse was retired at the time of the farmer's death and the deceased spouse materially participated in the farming activity for five of the last eight years prior to the deceased spouse's retirement, then the surviving spouse is deemed to be materially participating, even if the surviving spouse did not actively participate in the farming activity. See IRS Technical Service Memorandum 200911009, March 13, 2009.

(3) Limited partners of a limited partnership. The limited partners will not be treated as materially participating in any activity of a limited partnership except in a situation where the limited partner would be treated as materially participating under the material participation tests in subparagraphs 40.38(1)*"e"*(1), (5) and (6) above as if the taxpayer were not a limited partner for the tax year.

(4) Cash farm lease. A farmer who rents farmland on a cash basis will not generally be considered to be materially participating in the farming activity. The burden is on the landlord to show there was material participation in the cash-rent farm activity.

(5) Farm landlord involved in crop-share arrangement. A farm landlord is subject to self-employment tax on net income from a crop-share arrangement with a tenant. The landlord is considered to be materially participating with the tenant in the crop-share activity if the landlord meets one of the four following tests:

TEST 1. The landlord does any three of the following: (1) Pays or is obligated to pay for at least half the direct costs of producing the crop; (2) Furnishes at least half the tools, equipment, and livestock used in producing the crop; (3) Consults with the tenant; and (4) Inspects the production activities periodically.

TEST 2. The landlord regularly and frequently makes, or takes part in making, management decisions substantially contributing to or affecting the success of the enterprise.

TEST 3. The landlord worked 100 hours or more spread over a period of five weeks or more in activities connected with crop production.

TEST 4. The landlord has done tasks or performed duties which, considered in their total effect, show that the landlord was materially and significantly involved in the production of the farm commodities.

(6) Conservation reserve payments (CRP). Farmers entering into long-term contracts providing for less intensive use of highly erodible or other specified cropland can receive compensation for conversion of such land in the form of an "annualized rental payment." Although the CRP payments are referred to as "rental payments," the payments are considered to be receipts from farm operations and not rental payments from real estate.

If an individual is receiving CRP payments and is not considered to be retired from farming, the CRP payments are subject to self-employment tax. If individuals actively manage farmland placed in the CRP program by directly participating in seeding, mowing, and planting the farmland or by overseeing these activities and the individual is paying self-employment tax, the owner will be considered to have had material participation in the farming activity.

(7) Rental activities or businesses. For purposes of subrules 40.38(1) and 40.38(2), the general rule is that a taxpayer may have material participation in the rental activity unless covered by a specific exception in this subrule (for example, the exceptions for farm rental activities in subparagraphs 40.38(1)*"f"*(4), (5) and (6)). Rental activity or rental business is as the term is used in Section 469(c) of the Internal Revenue Code.

EXAMPLE. Ryan Stanley is an attorney who has owned two duplex units since 1998 and has received rental income from these duplexes since 1998. Mr. Stanley is responsible for the maintenance of the duplexes and may hire other individuals to perform repairs and other upkeep on the duplexes. However, no person spends more time in maintaining the duplexes than Mr. Stanley, and Mr. Stanley spends more than 100 hours per year in maintaining the duplexes. The duplexes are sold in 2011, resulting in a capital gain. Mr. Stanley can claim the capital gain deduction on the 2011 Iowa return since he met the material participation requirements for this rental activity.

(8) Like-kind exchanges and involuntary conversions. Material participation can be tacked on in cases of replacement property acquired under a like-kind exchange under Section 1031 of the Internal Revenue Code or an involuntary conversion under Section 1033 of the Internal Revenue Code.

EXAMPLE. Dustin James owned Farm A, and he materially participated in the operation of Farm A for 10 years. Mr. James executed a like-kind exchange for Farm B, and he materially participated in the operation of this farm for 4 years until he retired. Mr. James sold Farm B 2 years after he retired. Although he only materially participated in the operation of Farm B for 4 of the last 8 years before he retired, the operation of Farm A can be tacked on for purposes of the material participation test. Mr. James meets the material participation test since he participated in farming activity for the last 14 years before he retired.

(9) Record-keeping requirements. Detailed records should be kept by the taxpayer, on as close to a daily basis as possible, to verify that the material participation test has been met because the burden is on the taxpayer to demonstrate that the material participation test has been met. However, material participation can be established by any other reasonable means, such as approximating the number of hours based on appointment books, calendars, or narrative summaries.

40.38(2) *Net capital gains from the sale of real property used in a business.* Net capital gains from the sale of real property used in a business are excluded from net income on the Iowa return of the owner of a business to the extent that the owner had held the real property in the business for ten or more years and had materially participated in the business for at least ten years. For purposes of this provision, material participation is defined in Section 469(h) of the Internal Revenue Code and described in detail in subrule 40.38(1). It is not required that the property be located in Iowa for the owner to qualify for the deduction.

a. Meaning of the term "held" for purposes of this rule. For capital gains reported for tax years ending prior to January 1, 2006, the term "held" is defined as "owned." *James and Linda Bell,* Decision of the Administrative Law Judge, Docket No. 01DORF013, January 15, 2002, and *David V. and Julie K. Gorsche v. Iowa State Board of Tax Review,* Case No. CVCV 8379, Polk County District Court, May 5, 2011. Therefore, the property held by the taxpayer must have been owned by the taxpayer for ten or more years to meet the time held requirement for the capital gain deduction for tax years ending prior to January 1, 2006. For capital gains reported for tax years ending on or after January 1, 2006, the term "held" is determined using the holding period provisions set forth in Section 1223 of the Internal Revenue Code and the federal regulations adopted pursuant to Section 1223. Therefore, as long as the holding period used to compute the capital gain is ten years or more, the time held requirement for the capital gain deduction will be met for tax years ending on or after January 1, 2006.

b. Sale to a lineal descendant. For purposes of taxation of capital gains from the sale of real property of a business by a taxpayer, there is no waiver of the ten-year material participation requirement when the property is sold to a lineal descendant of the taxpayer as there is for capital gains from sales of businesses described in subrule 40.38(3).

c. In situations in which real property was sold by a partnership, subchapter S corporation, limited liability company, estate, or trust and the capital gain from the sale of the real property flows through to the owners of the business entity for federal income tax purposes, the owners may exclude the capital gain from their net incomes if the real property was held for ten or more years and the owners had materially participated in the business for ten years prior to the date of sale of the real property, irrespective of whether the type of business entity changed during the ten-year period prior to the date of sale. That is, if the owner of the business had held and materially participated in the business in the entire ten-year period before the sale, the fact that the business changed from one type of entity to another during the period does not disqualify the owner from excluding capital gains from the sale of real estate owned by the business during that whole ten-year period.

d. Installments received in the tax year from installment sales of businesses are eligible for the exclusion of capital gains from net income if all relevant criteria were met at the time of the installment sale. *Herbert Clausen and Sylvia Clausen v. Iowa Department of Revenue and Finance,* Law No. 32313, Crawford County District Court, May 24, 1995. For example, if a taxpayer received an installment payment in 2011 from the sale of a business that occurred in 2007, the installment received in 2011

would qualify for the exclusion if the taxpayer had held the business for ten or more years and had materially participated in the business for a minimum of ten years at the time of the sale in 2007.

e. Capital gains from the sale of real property by a C corporation do not qualify for the capital gain deduction except under the specific circumstances of a liquidation described in subrule 40.38(7).

f. Capital gains from the sale of real property held for ten or more years for speculation but not used in a business do not qualify for the capital gain deduction.

g. The following noninclusive examples illustrate how this subrule applies:

EXAMPLE 1. ABC Company, an S corporation, owned 1,000 acres of land. John Doe is the sole shareholder of ABC Company and had materially participated in ABC Company and held ABC Company for more than ten years at the time that 500 acres of the land were sold for a capital gain of $100,000 in 2011. The capital gain recognized in 2011 by ABC Company and which passed to John Doe as the shareholder of ABC Company is exempt from Iowa income tax because Mr. Doe met the material participation and time held requirements.

EXAMPLE 2. John Smith and Sam Smith both owned 50 percent of the stock in Smith and Company, which was an S corporation that held 1,000 acres of farmland. Sam Smith had managed all the farming operations for the corporation from the time the corporation was formed in 1990. John Smith was an attorney who lived and practiced law in Denver, Colorado. John Smith was the father of Sam Smith. In 2011, Smith and Company sold 200 acres of the farmland for a $50,000 gain. $25,000 of the capital gain passed through to John Smith and $25,000 of the capital gain passed through to Sam Smith. The farmland was sold to Jerry Smith, who was another son of John Smith. Both John Smith and Sam Smith had owned the corporation for at least ten years at the time the land was sold, but only Sam Smith had materially participated in the corporation for the last ten years. Sam Smith could exclude the $25,000 capital gain from the land sale because he had met the time held and material participation requirements. John Smith could not exclude the $25,000 capital gain since, although he had met the time held requirement, he did not meet the material participation requirement. Although the land sold by the corporation was sold to John Smith's son, a lineal descendant of John Smith, the capital gain John Smith realized from the land sale does not qualify for exemption for state income tax purposes. There is no waiver of the ten-year material participation requirement for a taxpayer's sale of real estate from a business to a lineal descendant of the taxpayer as is described for the sale of business assets in subrule 40.38(3).

EXAMPLE 3. Jerry Jones had owned and had materially participated in a farming business for 15 years and raised row crops in the business. There were 500 acres of land in the farming business; 300 acres had been held for 15 years, and 200 acres had been held for 5 years. If Mr. Jones sold the 200 acres of land that had been held only 5 years, any capital gain from the sale of this land would not be excludable since the land was part of the farming business but had been held for less than 10 years. If the 300 acres of land that had been held for 15 years had been sold, the capital gain from that sale would qualify for exclusion.

EXAMPLE 4. John Pike owned a farming business for more than ten years. In this business, Mr. Pike farmed a neighbor's land on a crop-share basis throughout the period. Mr. Pike bought 80 acres of land in 2004 and farmed that land until the land was sold in 2011 for a capital gain of $20,000. The capital gain was taxable on Mr. Pike's Iowa return since the farmland had been held for less than ten years although the business had been operated by Mr. Pike for more than ten years.

EXAMPLE 5. Joe and John Perry were brothers in a partnership for six years which owned 80 acres of land. The brothers dissolved the partnership in 2005, formed an S corporation, and included the land in the assets of the S corporation. The land was sold in 2011 to Brian Perry, who was the grandson of John Perry. The Perry brothers realized from the land sale a capital gain of $15,000, which was divided equally between the brothers. Joe Perry was able to exclude the capital gain he had received from the sale as he had held the land and had materially participated in the business for at least ten years at the time the land was sold. John Perry was unable to exclude the capital gain because, although he had owned the land for ten years, he had not materially participated in the business for ten years when the land was sold. The fact that the land was sold to a lineal descendant of John Perry is not relevant because the sale involved only real property held in a business and not the sale of all, or substantially all, of the tangible personal property and intangible property of the business.

EXAMPLE 6. Todd Myers had a farming business which he had owned and in which he had materially participated for 20 years. There were two tracts of farmland in the farming business. In 2011, he sold one tract of farmland in the farming business that he had held for more than 10 years for a $50,000 capital gain. The farmland was sold to a person who was not a lineal descendant. During the same year, Mr. Myers had $30,000 in long-term capital losses from sales of stock. In this situation, on Mr. Myers' 2011 Iowa return, the capital gains would not be applied against the capital losses. Because the capital losses are unrelated to the farming business, Mr. Myers does not have to reduce the Iowa capital gain deduction by the capital losses from the sales of stock.

EXAMPLE 7. Jim Casey had owned farmland in Greene County, Iowa, since 1987, and had materially participated in the farming business. In 1998, Mr. Casey entered into a like-kind exchange under Section 1031 of the Internal Revenue Code for farmland located in Carroll County, Iowa. Mr. Casey continued to materially participate in the farming business in Carroll County. The farmland in Carroll County was sold in 2005, resulting in a capital gain. For federal tax purposes, the holding period for the capital gain starts in 1987 under Section 1223 of the Internal Revenue Code. Because Mr. Casey held the farmland in Carroll County for less than ten years, based on Iowa law at the time of the sale, the capital gain from the sale does not qualify for the Iowa capital gain deduction. The deduction is not allowed even though the holding period for federal tax purposes is longer than ten years because the capital gain was reported for a tax year ending prior to January 1, 2006. If the farmland was sold in 2006, the gain would qualify for the capital gain deduction since the capital gain would have been reported for a tax year ending on or after January 1, 2006.

EXAMPLE 8. Jane and Ralph Murphy, a married couple, owned farmland in Iowa since 1975. Ralph died in 1994 and, under his will, Jane acquired a life interest in the farm. The farmland was managed by their son Joseph after Ralph's death. Jane died in 1998, and Joseph continued to materially participate and manage the farm operation. Joseph sold the farmland in 2006 and reported a capital gain. For federal tax purposes under Section 1223 of the Internal Revenue Code, the holding period for the capital gain starts in 1994, when Ralph died. Because the holding period for the capital gain was ten years or more under Section 1223 of the Internal Revenue Code, Joseph is entitled to the capital gain deduction under Iowa law since he materially participated for ten or more years and the capital gain was reported for a tax year ending on or after January 1, 2006.

40.38(3) *Net capital gains from the sale of assets of a business by an individual who had held the business for ten or more years and had materially participated in the business for ten or more years.* Net capital gains from the sale of the assets of a business are excluded from an individual's net income to the extent that the individual had held the business for ten or more years and had materially participated in the business for ten or more years. In addition to the time held and material participation qualifications for the capital gain deduction, the owner of the business must have sold substantially all of the tangible personal property or the service of the business in order for the capital gains to be excluded from taxation.

a. For purposes of this subrule, the phrase "substantially all of the tangible personal property or the service of the business" means that the sale of the assets of a business during the tax year must represent at least 90 percent of the fair market value of all of the tangible personal property and service of the business on the date of sale of the business assets. Thus, if the fair market value of a business's tangible personal property and service was $400,000, the business must sell tangible personal property and service of the business that had a fair market value of 90 percent of the total value of those assets to achieve the 90 percent or more standard. However, this does not mean that the amount raised from the sale of the assets must be $360,000 in order for the 90 percent standard to be met, only that the assets involved in the sale of the business must represent 90 percent of the total value of the business assets.

b. If the 90 percent of assets test is met, capital gains from other assets of the business can also be excluded. Some of these assets include, but are not limited to, stock of another corporation, bonds, including municipal bonds, and interests in other businesses. If the 90 percent test has been met, all of the individual assets of the business do not have to have been held for ten or more years on the date of sale for the capital gains from the sale of these assets to be excluded in computing the taxpayer's net income. This statement is made with the assumption that the taxpayer has owned the business and materially participated in the business for ten or more years prior to the sale of the assets of the business.

c. In most instances, the sale of merchandise or inventory of a business will not result in capital gains for the seller of a business, so the proceeds from the sale of these items would not be excluded from taxation.

d. For the purposes of this subrule, the term "service of the business" means intangible assets used in the business or for the production of business income which, if sold for a gain, would result in a capital gain for federal income tax purposes. Intangible assets that are used in the business or for the production of income include, but are not limited to, the following items: (1) goodwill, (2) going concern value, (3) information base, (4) patent, copyright, formula, design, or similar item, (5) client lists, and (6) any franchise, trademark, or trade name. The type of business that owns the intangible asset is immaterial, whether the business is a manufacturing business, a retail business, or a service business, such as a law firm or an accounting firm.

e. When the business held by the taxpayer for a minimum of ten years is sold to an individual or individuals who are all lineal descendants of the taxpayer, the taxpayer is not required to have materially participated in the business for ten years prior to the sale of the business in order for the capital gain to be excluded in the computation of net income. The term "lineal descendant" means children of the taxpayer, including legally adopted children and biological children, stepchildren, grandchildren, great-grandchildren, and any other lineal descendants of the taxpayer.

f. In situations in which substantially all of the tangible personal property or the service of the business was sold by a partnership, subchapter S corporation, limited liability company, estate, or trust and the capital gains from the sale of the assets flow through to the owners of the business entity for federal income tax purposes, the owners can exclude the capital gains from their net incomes if the owners had held the business for ten or more years and had materially participated in the business for ten years prior to the date of sale of the tangible personal property or service, irrespective of whether the type of business entity changed during the ten-year period prior to the sale. The criteria for material participation in a business may be found in subrule 40.38(1).

g. Installments received in the tax year from installment sales of businesses are eligible for the exclusion if all relevant criteria were met at the time of the installment sale. *Herbert Clausen and Sylvia Clausen v. Iowa Department of Revenue and Finance,* Law No. 32313, Crawford County District Court, May 24, 1995. For example, if a taxpayer received an installment payment in 2011 from the sale of a business that occurred in 2007, the installment received in 2011 would qualify for the exclusion if, at the time of the sale in 2007, the taxpayer had held the business for ten or more years and had materially participated in the business for a minimum of ten years.

h. Sale of capital stock of a corporation to a lineal descendant or to another individual does not constitute the sale of a business for purposes of the capital gain deduction, whether the corporation is a C corporation or an S corporation.

i. Capital gains from the sale of an ownership interest in a partnership, limited liability company or other entity are not eligible for the capital gain deduction. *Ranniger v. Iowa Department of Revenue and Finance,* Iowa Supreme Court, No. 11, 06-0761, March 21, 2008.

j. The sale of one activity of a business or one distinct part of a business may not constitute the sale of a business for purposes of this rule unless the activity or distinct part is a separate business entity such as a partnership or sole proprietorship which is owned by the business or unless the activity or distinct part of a business represents the sale of at least 90 percent of the fair market value of the tangible personal property or service of the business.

In order to determine whether the sale of the business assets constitutes the sale of a business for purposes of excluding capital gains recognized from the sale, refer to 701—subrule 54.2(1) relating to a unitary business. If activities or locations comprise a unitary business, then 90 percent or more of that unitary business must be sold to meet the requirement for capital gains from the sale to be excluded from taxation. If the activity or location constitutes a separate, distinct, nonunitary business, then 90 percent of the assets of that location or activity must be sold to qualify for the exclusion of the capital gain. The burden of proof is on the taxpayer to show that a sale of assets of a business meets the 90 percent standard.

k. The following noninclusive examples illustrate how this subrule applies:

EXAMPLE 1. Joe Rich is the sole owner of Eagle Company, which is an S corporation. In 2011, Mr. Rich sold all the stock of Eagle Company to his son, Mark Rich, and recognized a $100,000 gain on the sale of the stock. This capital gain would be taxable on Joe Rich's 2011 Iowa return since the sale of stock of a corporation did not constitute the sale of the tangible personal property and service of a business.

EXAMPLE 2. Randall Insurance Agency, a sole proprietorship, is owned solely by Peter Randall. In 2011, Peter Randall received capital gains from the sale of all tangible assets of the insurance agency. In addition, Mr. Randall had capital gains from the sale of client lists and goodwill to the new owners of the business. Since Mr. Randall had held the insurance agency for more than ten years and had materially participated in the insurance agency for more than ten years at the time of the sale of the tangible property and intangible property of the business, Mr. Randall can exclude the capital gains from the sale of the tangible assets and the intangible assets in computing net income on his 2011 Iowa return.

EXAMPLE 3. Joe Brown owned and materially participated in a sole proprietorship for more than ten years. During the 2011 tax year, Mr. Brown sold two delivery trucks and had capital gains from the sale of the trucks. At the time of sale, the trucks were valued at $30,000, which was about 10 percent of the fair market value of the tangible personal property of the business. Mr. Brown could not exclude the capital gains from the sale of the trucks on his 2011 Iowa return as the sale of those assets did not involve the sale of substantially all of the tangible personal property and service of Mr. Brown's business.

EXAMPLE 4. Rich Bennet owned a restaurant and a gift shop that were in the same building and were part of a sole proprietorship owned only by Mr. Bennet, who had held and materially participated in both business activities for over ten years. Mr. Bennet sold the gift shop in 2011 for $100,000 and had a capital gain of $40,000 from the sale. The total fair market value of all tangible personal property and intangible assets in the proprietorship at the time the gift shop was sold was $250,000. Mr. Bennet could not exclude the capital gain on his 2011 Iowa return because he had not sold at least 90 percent of the tangible and intangible assets of the business.

EXAMPLE 5. Joe and Ray Johnson were partners in a farm partnership that they had owned for 12 years in 2011 when the assets of the partnership were sold to Ray's son Charles. Joe Johnson had materially participated in the partnership for the whole time that the business was in operation, so he could exclude the capital gain he had received from the sale of the partnership assets. Although Ray Johnson had not materially participated in the farm business, he could exclude the capital gain he received from the sale of the assets of the partnership because the sale of the partnership assets was to his son, a lineal descendant.

EXAMPLE 6. Kevin and Ron Barker owned a partnership which owned a chain of six gas stations in an Iowa city. In 2011, the Barkers sold 100 percent of the property of two of the gas stations and received a capital gain of $30,000 from the sale. Separate business records were kept for each of the gas stations. Since the partnership was considered to be a unitary business and the Barkers sold less than 90 percent of the fair market value of the business, the Barkers could not exclude the capital gain from the sale of the gas stations from the incomes reported on their 2011 Iowa returns. However, any gain from the sale of the real property may qualify for exclusion, assuming the ten-year time held and material participation qualifications are met.

EXAMPLE 7. Rudy Stern owned a cafe in one Iowa city and a fast-food restaurant in another Iowa city. Mr. Stern had held both businesses and had materially participated in the operation of both businesses for ten years. Each business was operated with a separate manager and kept separate business records. In 2011, Mr. Stern sold all the tangible and intangible assets associated with the cafe and received a capital gain from the sale of the cafe. Mr. Stern can exclude the capital gain from his net income for 2011 because the cafe and fast-food restaurant were considered to be separate and distinct nonunitary businesses.

EXAMPLE 8. Doug Jackson is a shareholder in an S corporation, Jackson Products Corporation. Mr. Jackson has a 75 percent ownership interest in the S corporation, and he has materially participated in the operations of the S corporation since its incorporation in 1980. In 2008, Mr. Jackson transferred 10 percent of his ownership interest in the S corporation to Doug Jackson Irrevocable Trust. The income from the irrevocable trust was reported on Mr. Jackson's individual income tax return. In 2011, the assets

of Jackson Products Corporation were sold, resulting in a capital gain. Mr. Jackson can claim the capital gain deduction on both his 65 percent ownership held in his name and the 10 percent irrevocable trust ownership since the capital gain from the irrevocable trust flows through to Mr. Jackson's income tax return, and Mr. Jackson retained a 75 percent interest in the S corporation for more than ten years.

40.38(4) *Net capital gains from sales of cattle or horses used for certain purposes which were held for 24 months by taxpayers who received more than one-half of their gross incomes from farming or ranching operations.* Net capital gains from the sales of cattle or horses held for 24 months or more for draft, breeding, dairy, or sporting purposes qualify for the capital gain deduction if more than 50 percent of the taxpayer's gross income in the tax year is from farming or ranching operations. Proper records should be kept showing purchase and birth dates of cattle and horses. The absence of records may make it impossible for the owner to show that the owner held a particular animal for the necessary holding period. Whether cattle or horses are held for draft, breeding, dairy, or sporting purposes depends on all the facts and circumstances of each case.

a. Whether cattle or horses sold by the taxpayer after the taxpayer has held them 24 months or more were held for draft, breeding, dairy, or sporting purposes may be determined from federal court cases on such sales and the standards and examples included in 26 CFR §1.1231-2.

b. In situations where the qualifying cattle or horses are sold by the taxpayer to a lineal descendant of the taxpayer, the taxpayer does not need to have had more than 50 percent of gross income in the tax year from farming or ranching activities in order for the capital gain to be excluded.

c. Capital gains from sales of qualifying cattle or horses by an S corporation, partnership, or limited liability company, where the capital gains flow through to the individual owners for federal income tax purposes, are eligible for the exclusion only in situations in which the individual owners have more than 50 percent of their gross incomes in the tax year from farming or ranching activities, or where the sale of the qualifying cattle or horses was to lineal descendants of the owners reporting the capital gains from the sales of the qualifying cattle or horses.

d. Capital gains from sales of qualifying cattle or horses by a C corporation are not eligible for the capital gain deduction.

e. A taxpayer's gross income from farming or ranching includes amounts the individual has received in the tax year from cultivating the soil or raising or harvesting any agricultural commodities. Gross income from farming or ranching includes the income from the operation of a stock, dairy, poultry, fish, bee, fruit, or truck farm, plantation, ranch, nursery, range, orchard, or oyster bed, as well as income in the form of crop shares received from the use of the taxpayer's land. Gross income from farming or ranching also includes total gains from sales of draft, breeding, dairy, or sporting livestock. In the case of individual income tax returns for the 2011 tax year, gross income from farming or ranching includes the total of the amounts from line 9 or line 50 of Schedule F and line 7 of Form 4835, Farm Rental Income and Expenses, plus the share of partnership income from farming, the share of distributable net taxable income from farming of an estate or trust, and total gains from the sale of livestock held for draft, breeding, dairy, or sporting purposes, as shown on Form 4797, Sale of Business Property. In the case of an individual's returns for tax years beginning after 2011, equivalent lines from returns and supplementary forms would be used to determine a taxpayer's gross income from farming or ranching for those years.

To make the calculation as to whether more than half of the taxpayer's gross income in the tax year is from farming or ranching operations, the gross income from farming or ranching as determined in the previous paragraph is divided by the taxpayer's total gross income. If the resulting percentage is greater than 50 percent, the taxpayer's capital gains from sales of cattle and horses will be considered for the capital gain deduction.

In instances where married taxpayers file a joint return, the gross income from farming or ranching of both spouses will be considered for the purpose of determining whether the taxpayers received more than half of their gross income from farming or ranching. However, in situations where married taxpayers file separate Iowa returns or separately on the combined return form, each spouse must separately determine whether that spouse has more than 50 percent of gross income from farming or ranching operations.

EXAMPLE. Bob Deen had a cattle operation that owned black angus cattle in the operation for breeding purposes. In 2011, Mr. Deen sold 40 head of cattle that had been held for breeding purposes for two years. Mr. Deen's total gross income from farming was $125,000, but he had a $10,000 loss from his farming operation. Mr. Deen also had wages of $25,000 from a job at a local farming cooperative. Because Mr. Deen had more than 50 percent of his gross income in 2011 from farming operations, he could exclude the capital gain from the sale of the breeding cattle. Although Mr. Deen had a loss from his farming activities, he still had more than 50 percent of his gross income in the tax year from those activities.

40.38(5) *Net capital gains from sale of breeding livestock, other than cattle or horses, held for 12 or more months by taxpayers who received more than one-half of their gross incomes from farming or ranching operations.* Net capital gains from the sale of breeding livestock, other than cattle or horses, held for 12 or more months from the date of acquisition qualify for the capital gain deduction, if more than one-half of the taxpayer's gross income is from farming or ranching. For the purposes of this subrule, "livestock" has a broad meaning and includes hogs, mules, donkeys, sheep, goats, fur-bearing mammals, and other mammals. Livestock does not include poultry, chickens, turkeys, pigeons, geese, other birds, fish, frogs, or reptiles. If livestock other than cattle or horses is considered to have been held for breeding purposes under the criteria established in 26 CFR §1.1231-2, the livestock will also be deemed to have been breeding livestock for purposes of this subrule. In addition, for the purposes of this subrule livestock does not include cattle and horses held for 24 or more months for draft, breeding, dairy, or sporting purposes which were described in subrule 40.38(4).

a. The procedure in subrule 40.38(4) for determining whether more than one-half of a taxpayer's gross income is from farming or ranching operations is also applicable for this subrule.

b. In an instance in which a taxpayer sells breeding livestock other than cattle or horses which have been held for 12 or more months, and the sale of the livestock is to a lineal descendant of the taxpayer, the taxpayer is not required to have more than one-half of the gross income in the tax year from farming or ranching operations to be eligible for the capital gain deduction.

c. Capital gains from sales of qualifying livestock other than cattle or horses by an S corporation, partnership, or limited liability company, where the capital gains flow through to the owners of the respective business entity for federal income tax purposes, qualify for the capital gain deduction to the extent the owners receiving the capital gains meet the qualifications for the deduction on the basis of having more than one-half of the gross income in the tax year from farming or ranching operations.

d. Capital gains from the sale of qualifying livestock other than cattle or horses by a C corporation are not eligible for the capital gain deduction.

40.38(6) *Net capital gains from sales of timber held by the taxpayer for more than one year.* Capital gains from qualifying sales of timber held by the taxpayer for more than one year are eligible for the capital gain deduction. In all of the following examples of circumstances where gains from sales of timber qualify for capital gain treatment, it is assumed that the timber sold was held by the owner for more than one year at the time the timber was sold. The owner of the timber can be the owner of the land on which the timber was cut or the holder of a contract to cut the timber. In the case where a taxpayer sells standing timber the taxpayer held for investment, any gain from the sale is a capital gain. Timber includes standing trees usable for lumber, pulpwood, veneer, poles, pilings, cross ties, and other wood products. Timber eligible for the capital gain deduction does not apply to sales of pulpwood cut by a contractor from the tops and limbs of felled trees. Under the general rule, the cutting of timber results in no gain or loss, and it is not until the sale or exchange that gain or loss is realized. But if a taxpayer owned or had a contractual right to cut timber, the taxpayer may make an election to treat the cutting of timber as a sale or exchange in the year the timber is cut. Gain or loss on the cutting of the timber is determined by subtracting the adjusted basis for depletion of the timber from the fair market value of the timber on the first day of the tax year in which the timber is cut. For example, the gain on this type of transaction is computed as follows:

Fair market value of timber on January 1, 2011	$400,000
Adjusted basis for depletion	− $100,000
Capital gain on cutting of timber	$300,000

The fair market value shown above of $400,000 is the basis of the timber. A later sale of the cut timber including treetops and stumps would result in ordinary income for the taxpayer and not a capital gain.

a. Evergreen trees, such as those used as Christmas trees, that are more than six years old at the time they are severed from their roots and sold for ornamental purposes, are included in the definition of timber for purposes of this subrule. The term "evergreen trees" is used in its commonly accepted sense and includes pine, spruce, fir, hemlock, cedar, and other coniferous trees. Where customers of the taxpayer cut down the Christmas tree of their choice on the taxpayer's farm, there is no sale until the tree is cut. However, evergreen trees sold in a live state do not qualify for capital gain treatment.

b. Capital gains or losses also are received from sales of timber by a taxpayer who has a contract which gives the taxpayer an economic interest in the timber. The date of disposal of the timber shall be the day the timber is cut, unless payment for the timber is received before the timber is cut. Under this circumstance, the taxpayer may treat the date of the payment as the date of disposal of the timber. Additional information about gains and losses from the sale of timber is included under 26 CFR §1.631-1 and §1.631-2.

c. Capital gains from the sale of qualifying timber by an S corporation, partnership, or limited liability company, which flow to the owners of the respective business entity for federal individual income tax purposes, are eligible for the capital gain deduction.

d. Capital gains from the sale of timber by a C corporation do not qualify for the capital gain deduction.

40.38(7) *Capital gains from the liquidation of assets of corporations which are recognized as sales of assets for federal income tax purposes.* Capital gains realized from liquidations of corporations which are recognized as sales of assets for federal income tax purposes under Section 331 of the Internal Revenue Code may be eligible for the capital gain deduction. To the extent the capital gains are reported by the shareholders of the corporations for federal income tax purposes and the shareholders are individuals, the shareholders are eligible for the capital gain deduction if the shareholders meet the qualifications for time of ownership and time of material participation in the corporation being liquidated. The burden of proof is on the shareholders to show they meet these time of ownership and material participation requirements.

40.38(8) *Capital gains from certain stock sales which are treated as acquisitions of assets of the corporation for federal income tax purposes.* Capital gains received by individuals from a sale of stock of a target corporation which is treated as an acquisition of the assets of the corporation under Section 338 of the Internal Revenue Code may be excluded if the individuals receiving the capital gains had held an interest in the target corporation and had materially participated in the corporation for ten years prior to the date of the sale of the corporation. The burden of proof is on the taxpayer to show eligibility to exclude the capital gains from these transactions in the computation of net income for Iowa individual income tax purposes.

40.38(9) *Treatment of capital gain deduction for tax years with net operating losses and for tax years to which net operating losses are carried.* The following paragraphs describe the tax treatment of the capital gain deduction in a tax year with a net operating loss and the tax treatment of a capital gain deduction in a tax year to which a net operating loss was carried:

a. The capital gain deduction otherwise allowable on a return is not allowed for purposes of computing a net operating loss from the return which can be carried to another tax year and applied against the income for the other tax year.

EXAMPLE. Joe Jones filed a 2011 return showing a net loss of $12,000. On this return, Mr. Jones claimed a capital gain deduction of $3,000 from sale of breeding livestock, other than cattle or horses, held for 12 months or more which was considered in computing the loss of $12,000. However, the $3,000

capital gain deduction is not allowed in the computation of the net operating loss deduction for 2011 for purposes of carrying the net operating loss deduction to another tax year. Thus, the net operating loss deduction for 2011 is $9,000.

b. In the case of net operating losses which are carried back to a tax year where the taxpayer has claimed the capital gain deduction, the capital gain deduction is not allowed for purposes of computing the income to which the net operating loss deduction is applied.

EXAMPLE. John Brown had a net operating loss of $20,000 on the Iowa return he filed for 2011. Mr. Brown elected to carry back the net operating loss to his 2009 Iowa return. The 2009 return showed a taxable income of $27,000 which included a capital gain deduction of $3,000. For purposes of computing the income in the carryback year to which the net operating loss would be applied, the income was increased by $3,000 to disallow the capital gain deduction properly allowed in computing taxable income for the carryback year. Therefore, the net operating loss deduction from 2011 was applied to an income of $30,000 for the carryback year.

This rule is intended to implement Iowa Code section 422.7.

[**ARC 7761B**, IAB 5/6/09, effective 6/10/09; **ARC 0073C**, IAB 4/4/12, effective 5/9/12]

701—40.39(422) Exemption of interest from bonds or notes issued to fund the E911 emergency telephone system. Interest received on or after May 4, 1990, from bonds or notes issued by the Iowa finance authority to fund the E911 emergency telephone system is exempt from the state income tax.

This rule is intended to implement Iowa Code sections 422.7 and 477B.20.

701—40.40(422) Exemption of active-duty military pay of national guard personnel and armed forces reserve personnel received for services related to operation desert shield. For tax years ending on or after August 2, 1990, military pay received by persons in the national guard and persons in the armed forces military reserve is exempt from state income tax to the extent the military pay is not otherwise excluded from taxation and the military pay is for active-duty military service on or after August 2, 1990, pursuant to military orders related to Operation Desert Shield. The exemption applies to individuals called to active duty in Iowa to replace other persons who were in military units who were called to serve on active duty outside Iowa provided the military orders specify that the active duty assignment in Iowa pertains to Operation Desert Shield.

Persons filing original returns or amended returns on Form IA 1040X for tax years where the exempt income was received should print the notation, "Operation Desert Shield" at the top of the original return form or amended return form. A copy of the military orders showing the person was called to active duty and was called in support of Operation Desert Shield should be attached to the original return form or amended return form to support the exemption of the active duty military pay.

This rule is intended to implement Iowa Code section 422.7.

701—40.41(422) Disallowance of private club expenses. Rescinded IAB 11/24/04, effective 12/29/04.

701—40.42(422) Depreciation of speculative shell buildings.

40.42(1) For tax years beginning on or after January 1, 1992, speculative shell buildings constructed or reconstructed after that date may be depreciated as 15-year property under the accelerated cost recovery system of the Internal Revenue Code. If the taxpayer has deducted depreciation on the speculative shell building on the taxpayer's federal income tax return, that amount of depreciation must be added to the federal adjusted gross income in order to deduct depreciation computed under this rule.

40.42(2) On sale or other disposition of the speculative building, the taxpayer must report on the taxpayer's Iowa individual income tax return the same gain or loss as is reported on the taxpayer's federal individual income tax return. If, while owned by the taxpayer, the building is converted from a speculative shell building to another use, the taxpayer must deduct the same amount of depreciation on the taxpayer's Iowa tax return as is deducted on the taxpayer's federal tax return.

40.42(3) For the purposes of this rule, the term "speculative shell building" means a building as defined in Iowa Code section 427.1(27)*"c."*

This rule is intended to implement Iowa Code section 422.7.

701—40.43(422) Retroactive exemption for payments received for providing unskilled in-home health care services to a relative. Retroactive to January 1, 1988, for tax years beginning on or after that date, supplemental assistance payments authorized under Iowa Code section 249.3(2)*"a"*(2) which are received by an individual providing unskilled in-home health care services to a member of the caregiver's family are exempt from state income tax to the extent that the individual caregiver is not a licensed health care professional designated in Iowa Code section 147.13, subsections 1 to 10.

For purposes of this exemption, a member of the caregiver's family includes a spouse, parent, stepparent, child, stepchild, brother, stepbrother, sister, stepsister, lineal ancestor such as grandparent and great-grandparent, and lineal descendant such as grandchild and great-grandchild, and those previously described relatives who are related by marriage or adoption. Those licensed health care professionals who are not eligible for this exemption include medical doctors, doctors of osteopathy, physician assistants, psychologists, podiatrists, chiropractors, physical therapists, occupational therapists, nurses, dentists, dental hygienists, optometrists, speech pathologists, audiologists, and other similar licensed health care professionals.

This rule is intended to implement Iowa Code section 422.7.

[**ARC 7761B**, IAB 5/6/09, effective 6/10/09; **ARC 8589B**, IAB 3/10/10, effective 4/14/10]

701—40.44(422,541A) Individual development accounts. Individual development accounts are authorized for low-income taxpayers for tax years beginning on or after January 1, 1994. Additions to the accounts are described in the following subrule:

40.44(1) *Exemption of additions to individual development accounts.* The following additions to individual development accounts are exempt from the state income tax of the owners of the accounts to the extent the additions were subject to federal income tax:

a. The amount of contributions made in the tax year to an account by persons and entities other than the owner of the account.

b. The amount of any savings refund or state match payments made in the tax year to an account as authorized for contributions made to the accounts by the owner of the account.

c. Earnings on the account in the tax year or interest earned on the account.

40.44(2) *Additions to net income for withdrawals from individual development accounts.* Rescinded IAB 9/11/96, effective 10/16/96.

This rule is intended to implement Iowa Code sections 422.7, 541A.2 and 541A.3 as amended by 2008 Iowa Acts, Senate File 2430.

701—40.45(422) Exemption for distributions from pensions, annuities, individual retirement accounts, or deferred compensation plans received by nonresidents of Iowa. For tax years beginning on or after January 1, 1994, a distribution from a pension plan, annuity, individual retirement account, or deferred compensation plan which is received by a nonresident of Iowa is exempt from Iowa income tax to the extent the distribution is directly related to the documented retirement of the pensioner, annuitant, owner of individual retirement account, or participant in a deferred compensation arrangement. For tax years beginning on or after January 1, 1996, distributions of nonqualified retirement benefits which are paid by a partnership to its retired partners and which are received by a nonresident of Iowa are exempt from Iowa income tax to the extent the distribution is directly related to the documented retirement of the partner. In a situation where the pensioner, annuitant, owner of the individual retirement account, or participant of a deferred compensation arrangement dies before the date of documented retirement, any distribution from the pension, annuity, individual retirement account, or deferred compensation arrangement will not be taxable to the beneficiary receiving the distributions if the beneficiary is a nonresident of Iowa. If the pensioner, annuitant, owner of the individual retirement account, or participant of a deferred compensation arrangement dies after the date of documented retirement, any distributions from the pension, annuity, individual retirement account, or deferred compensation arrangement will not be taxable to a beneficiary receiving distributions if the beneficiary is a nonresident of Iowa.

For purposes of this rule, the distributions from the pensions, annuities and deferred compensation arrangements were from pensions, annuities, and deferred compensation earned entirely or at least partially from employment or self-employment in Iowa. For purposes of this rule, distributions from individual retirement arrangements were from individual retirement arrangements that were funded by contributions from the arrangements that were deductible or partially deductible on the Iowa income tax return of the owner of the individual retirement accounts.

The following subrules include definitions and examples which clarify when distributions from pensions, annuities, individual retirement accounts, and deferred compensation arrangements are exempt from Iowa income tax, when the distributions are received by nonresidents of Iowa:

40.45(1) *Definitions.*

a. The word "beneficiary" means an individual who receives a distribution from a pension or annuity plan, individual retirement arrangement, or deferred compensation plan as a result of either the death or divorce of the pensioner, annuitant, participant of a deferred compensation arrangement, or owner of an individual retirement account.

b. The term "individual's documented retirement" means any evidence that the individual can provide to the department of revenue which would establish that the individual or the individual's beneficiary is receiving distributions from the pension, annuity, individual retirement account, or the deferred compensation arrangement due to the retirement of the individual.

Examples of documents that would establish an individual's retirement may include: copies of birth certificates or driver's licenses to establish an individual's age; copies of excerpts from an employer's personnel manual or letter from employer to establish retirement or early retirement policies; a copy of a statement from a physician to establish an individual's disability which could have contributed to a person's retirement.

c. The term "nonresident" applies only to individuals and includes all individuals other than those individuals domiciled in Iowa and those individuals who maintain a permanent place of abode in Iowa. See 701—subrule 38.17(2) for the definition of domicile.

40.45(2) *Examples:*

a. John Jones had worked for the same Iowa employer for 32 years when he retired at age 62 and moved to Arkansas in March of 1994. Mr. Jones started receiving distributions from the pension plan from his former employer starting in May 1994. Because Mr. Jones was able to establish that he was receiving the distributions from the pension plan due to his retirement from his employment, Mr. Jones was not subject to Iowa income tax on the distributions from the pension plan. Note that Mr. Jones had sold his Iowa residence in March and established his domicile in Arkansas at the time of his move to Arkansas.

b. Wanda Smith was the daughter of John Smith who died in February 1994 after 25 years of employment with a company in Urbandale, Iowa. Wanda Smith was the sole beneficiary of John and started receiving distributions from John's pension in April 1994. Wanda Smith was a bona fide resident of Oakland, California, when she received distributions from her father's pension. Wanda was not subject to Iowa income tax on the distributions since she was a nonresident of Iowa at the time the distributions were received.

c. Martha Graham was 55 years old when she quit her job with a firm in Des Moines to take a similar position with a firm in Dallas, Texas. Ms. Graham had worked for the Des Moines business for 22 years before she resigned from the job in May 1994. Starting in July 1994, Ms. Graham received monthly distributions from the pension from her former Iowa employer. Although Ms. Graham was a nonresident of Iowa, she was subject to Iowa income tax on the pension distribution since the taxpayer didn't have a documented retirement.

d. William Moore was 58 years old when he quit his job with a bank in Mason City in February 1994 after 30 years of employment with the bank. By the time Mr. Moore started receiving pension payments from his employment with the bank, he had moved permanently to New Mexico. Shortly after he arrived in New Mexico, Mr. Moore secured part-time employment. The pension payments were not taxable to Iowa as Mr. Moore was retired notwithstanding his part-time employment in New Mexico.

e. Joe Brown had worked for an Iowa employer for 25 years when he retired in June 1992 at the age of 65. Mr. Brown started receiving monthly pension payments in July 1992. Mr. Brown resided in Iowa until August 1994, when he moved permanently to Nevada to be near his daughter. Mr. Brown was not taxable to Iowa on the pension payments he received after his move to Nevada. Mr. Brown's retirement occurred in June 1992 when he resigned from full-time employment.

This rule is intended to implement Iowa Code section 422.8.

701—40.46(422) Taxation of compensation of nonresident members of professional athletic teams. Effective for tax years beginning on or after January 1, 1995, the Iowa source income of a nonresident individual who is a member of a professional athletic team includes the portion of the individual's total compensation for services provided for the athletic team that is in the ratio that the number of duty days spent in Iowa rendering services for the team during the tax year bears to the total number of duty days spent both within and without Iowa in the tax year. Thus, if a nonresident member of a professional athletic team has $50,000 in total compensation from the team in 1995 and the athlete has 20 Iowa duty days and 180 total duty days for the team in 1995, $5,556 of the compensation would be taxable to Iowa ($50,000 × 20/180 = $5,556).

The following subrules include definitions, examples, and other information which clarify Iowa's taxation of nonresident members of professional athletic teams:

40.46(1) *Definitions.*

a. The term "professional athletic team" includes, but is not limited to, any professional baseball, basketball, football, soccer, or hockey team.

b. The term "member of a professional athletic team" includes those employees who are active players, players on the disabled list, and any other persons required to travel and who travel with and perform services on behalf of a professional athletic team on a regular basis. This includes, but is not limited to, coaches, managers, and trainers.

c. The term "total compensation for services rendered as a member of a professional athletic team" means the total compensation received during the taxable year for services rendered. "Total compensation" includes, but is not limited to, salaries, wages, bonuses (as described in subparagraph (1) of this paragraph), and any other type of compensation paid during the taxable year to a member of a professional athletic team for services performed in that year. Such compensation does not include strike benefits, severance pay, termination pay, contract or option year buy-out payments, expansion or relocation payments, and any other payments not related to services rendered for the team.

For purposes of this paragraph, "bonuses" included in "total compensation for services rendered as a member of a professional athletic team" subject to the allocation described in this rule are:

(1) Bonuses earned as a result of play (i.e., performance bonuses) during the season, including bonuses paid for championship, playoff, or "bowl" games played by a team, or for the member's selection to all-star, league, or other honorary positions; and

(2) Bonuses paid for signing a contract, unless all of the following conditions are met:

1. The payment of the signing bonus is not conditional upon the signee playing any games for the team, or performing any subsequent services for the team, or even making the team;
2. The signing bonus is payable separately from the salary and any other compensation; and
3. The signing bonus is nonrefundable.

d. Except as provided in subparagraphs (4) and (5) of this paragraph, the term "duty days" means all days during the taxable year from the beginning of the professional athletic team's official preseason training period through the last game in which the team competes or is scheduled to compete. Duty days are included in the allocation described in this rule for the tax year in which they occur, including where a team's official preseason training period through the last game in which the team competes, or is scheduled to compete, occurs during more than one tax year.

(1) Duty days also includes days on which a member of a professional athletic team renders a service for a team on a date which does not fall within the previously mentioned period (e.g., participation in instructional leagues, the "Pro Bowl" or promotional "caravans"). Rendering a service

includes conducting training and rehabilitation activities, but only if conducted at the facilities of the team.

(2) Included within duty days are game days, practice days, days spent at team meetings, promotional caravans and preseason training camps, and days served with the team through all postseason games in which the team competes or is scheduled to compete.

(3) Duty days for any person who joins a team during the period from the beginning of the professional athletic team's official preseason training period through the last game in which the team competes, or is scheduled to compete, begins on the day the person joins the team. Conversely, duty days for any person who leaves a team during such period ends on the day the person leaves the team. When a person switches teams during a taxable year, separate duty day calculations are to be made for the period the person was with each team.

(4) Days for which a member of a professional athletic team is not compensated and is not rendering services for the team in any manner, including days when the member of a professional athletic team has been suspended without pay and prohibited from performing any services for the team, are not to be treated as duty days.

(5) Days for which a member of a professional athletic team is on the disabled list and does not conduct rehabilitation activities at facilities of the team and is not otherwise rendering services for the team in Iowa, are not to be considered duty days spent in Iowa. However, all days on the disability list are considered to be included in total duty days spent both within and outside the state of Iowa.

(6) Total duty days for members of a professional athletic team that are not professional athletes are the number of days in the year that the members are employed by the professional athletic team. Thus, in the case of a coach of a professional athletic team who was coach for the entire year of 1995, the coach's total duty days for 1995 would be 365.

(7) Travel days in Iowa by a team member that do not involve a game, practice, team meeting, all-star game, or other personal service for the team are not considered to be duty days in Iowa. However, to the extent these days fall within the period from the team's preseason training period through the team's final game, these Iowa travel days will be considered in the total duty days spent within and outside Iowa, for team members who are professional athletes.

(8) Duty days in Iowa do not include days a team member performs personal services for the professional athletic team in Iowa on those days that the team member is a bona fide resident of a state with which Iowa has a reciprocal tax agreement. See rule 701—38.13(422).

40.46(2) *Filing composite Iowa returns for nonresident members of professional athletic teams.* Professional athletic teams may file composite Iowa returns on behalf of team members who are nonresidents of Iowa and who have compensation that is taxable to Iowa from duty days in Iowa for the athletic team. However, the athletic team may include on the composite return only those team members who are nonresidents of Iowa and who have no Iowa source incomes other than the incomes from duty days in Iowa for the team. The athletic team may exclude from the composite return any team member who is a nonresident of Iowa and whose income from duty days in Iowa is less than $1,000. See rule 701—48.1(422) about filing Iowa composite returns.

40.46(3) *Examples of taxation of nonresident members of professional athletic teams.*

a. Player A, a member of a professional athletic team, is a nonresident of Iowa. Player A's contract for the team requires A to report to such team's training camp and to participate in all exhibition, regular season, and playoff games. Player A has a contract which covers seasons that occur during year 1/year 2 and year 2/year 3. Player A's contract provides that A is to receive $500,000 for the year 1/year 2 season and $600,000 for the year 2/year 3 season. Assuming player A receives $550,000 from the contract during taxable year 2 ($250,000 for one-half the year 1/year 2 season and $300,000 for one-half the year 2/year 3 season), the portion of compensation received by player A for taxable year 2, attributable to Iowa, is determined by multiplying the compensation player A receives during the taxable year ($550,000) by a fraction, the numerator of which is the total number of duty days player A spends rendering services for the team in Iowa during taxable year 2 (attributable to both the year 1/year 2 season and the year 2/year 3 season) and the denominator of which is the total number of player A's duty days spent both within and outside Iowa for the entire taxable year.

b. Player B, a member of a professional athletic team, is a nonresident of Iowa. During the season, B is injured and is unable to render services for B's team. While B is undergoing medical treatment at a clinic, which is not a facility of the team, but is located in Iowa, B's team travels to Iowa for a game. The number of days B's team spends in Iowa for practice, games, meetings, for example, while B is present at the clinic, are not to be considered duty days spent in Iowa for player B for that taxable year for purposes of this rule, but these days are considered to be included within total duty days spent both within and outside Iowa.

c. Player C, a member of a professional athletic team, is a nonresident of Iowa. During the season, C is injured and is unable to render services for C's team. C performs rehabilitation exercises at the facilities of C's team in Iowa as well as at personal facilities in Iowa. The days C performs rehabilitation exercise in the facilities of C's team are considered duty days spent in Iowa for player C for that taxable year for purposes of this rule. However, days player C spends at personal facilities in Iowa are not to be considered duty days spent in Iowa for player C for that taxable year for purposes of this rule, but the days are considered to be included within total duty days spent both within and outside Iowa.

d. Player D, a member of a professional athletic team, is a nonresident of Iowa. During the season, D travels to Iowa to participate in the annual all-star game as a representative of D's team. The number of days D spends in Iowa for practice, the game, meetings, for example, are considered to be duty days spent in Iowa for player D for that taxable year for purposes of this rule, as well as included within total duty days spent both within and outside Iowa.

e. Assume the same facts as given in paragraph *"d,"* except that player D is not participating in the all-star game and is not rendering services for D's team in any manner. Player D is instead traveling to and attending this game solely as a spectator. The number of days player D spends in Iowa for the game is not to be considered to be duty days spent in Iowa for purposes of this rule. However, the days are considered to be included within total duty days spent both within and outside Iowa.

40.46(4) *Use of an alternative method to compute taxable portion of a nonresident's compensation as a member of a professional athletic team.* If a nonresident member of a professional athletic team believes that the method provided in this rule for allocation of the member's compensation to Iowa is not equitable, the nonresident member may propose the use of an alternative method for the allocation of the compensation to Iowa. The request for an alternative method for allocation must be filed no later than 60 days before the due date of the return, considering that the due date may be extended for up to 6 months after the original due date if at least 90 percent of the tax liability was paid by the original due date (April 30 for taxpayers filing on a calendar-year basis).

The request for an alternative method should be filed with the Taxpayer Services and Policy Division, P.O. Box 10457, Des Moines, Iowa 50306. The request must set forth the alternative method for allocation to Iowa of the compensation of the nonresident professional team member. In addition, the request must specify, in detail, why the method for allocation of the compensation set forth in this rule is not equitable, as well as why the alternative method for allocation of the compensation is more equitable than the method provided in this rule. The burden of proof is on the nonresident professional team member to show that the alternative method is more equitable than the method provided in the rule.

If the department determines that the alternative method is more reasonable for allocation of the taxable portion of the team member's compensation than the method provided in this rule, the team member can use the alternative method on the current return and on subsequent returns.

If the department rejects the team member's use of the alternative method, the team member may file a protest within 60 days of the date of the department's letter of rejection. The nonresident team member's protest of the department's rejection of the alternate formula must be made in accordance with rule 701—7.41(17A) and must state, in detail, why the method provided in this rule is not equitable, as well as why the alternative method for allocation of the compensation is more equitable than the method set forth in this rule.

This rule is intended to implement Iowa Code sections 422.3, 422.7, and 422.8.

[**ARC 7761B**, IAB 5/6/09, effective 6/10/09]

701—40.47(422) Partial exclusion of pensions and other retirement benefits for disabled individuals, individuals who are 55 years of age or older, surviving spouses, and survivors. For tax years beginning on or after January 1, 1995, an individual who is disabled, is 55 years of age or older, is a surviving spouse, or is a survivor with an insurable interest in an individual who would have qualified for the exclusion is eligible for a partial exclusion of retirement benefits received in the tax year. For tax years beginning on or after January 1, 2001, the partial exclusion of retirement benefits received in the tax year is increased up to a maximum of $6,000 for a person other than a husband or wife who files a separate state return and up to a maximum of $12,000 for a husband and wife who file a joint Iowa return. For tax years beginning on or after January 1, 1998, the partial exclusion of retirement benefits received in the tax year was increased up to a maximum of $5,000 for a person, other than a husband or wife who files a separate state income tax return, and up to a maximum of $10,000 for a husband and wife who file a joint state income tax return. A husband and wife filing separate state income tax returns or separately on a combined state return are allowed a combined exclusion of retirement benefits of up to a maximum of $10,000 for tax years beginning in 1998, 1999 and 2000 and a combined exclusion of up to a maximum of $12,000 for tax years beginning on or after January 1, 2001. The $10,000 or $12,000 exclusion shall be allocated to the husband and wife in the proportion that each spouse's respective pension and retirement benefits received bear to the total combined pension and retirement benefits received by both spouses.

EXAMPLE 1. A married couple elected to file separately on the combined return form. Both spouses were 55 years of age or older. The wife received $95,000 in retirement benefits and the husband received $5,000 in retirement benefits. Since the wife received 95 percent of the retirement benefits, she would be entitled to 95 percent of the $10,000 retirement income exclusion or a retirement income exclusion of $9,500. The husband would be entitled to 5 percent of the $10,000 retirement income exclusion or an exclusion of $500.

EXAMPLE 2. A married couple elected to file separately on the combined return form. Both spouses were 55 years of age or older. The husband had $15,000 in retirement benefits from a pension. The wife received no retirement benefits. In this situation, the husband can use the entire $10,000 retirement income exclusion to exclude $10,000 of his pension benefits since the spouse did not use any of the $10,000 retirement income exclusion for the tax year.

EXAMPLE 3. A married couple elected to file separately on the combined return form. One spouse was 52 years of age and received a pension income of $20,000. The other spouse was 55 years of age and received no pension income. Since the spouse receiving the pension income was not 55 years of age, no exclusion is allowed on the Iowa return.

EXAMPLE 4. A married couple elected to file separately on the combined return form. One spouse was 52 years of age and received a pension income of $10,000. The other spouse was 55 years of age and received a pension income of $8,000. Since only one spouse receiving the pension income was 55 years of age, an exclusion of $8,000 is allowed on the Iowa return. The exclusion of $8,000 is allowed since a married couple is allowed a combined exclusion of up to $12,000.

For tax years beginning on or after January 1, 1995, but prior to January 1, 1998, the retirement income exclusion was up to $3,000 for single individuals, up to $3,000 for each married person filing a separate Iowa return, up to $3,000 for each married person filing separately on the combined return form, and up to $6,000 for married taxpayers filing joint Iowa returns. For example, a married couple elected to file separately on the combined return form and both spouses were 55 years of age or older. One spouse had $2,000 in pension income that could be excluded, since the pension income was $3,000 or less. The other spouse had $6,000 in pension income and could exclude $3,000 of that income due to the retirement income exclusion. This second spouse could not exclude an additional $1,000 of the up to $3,000 retirement income exclusion that was not used by the other spouse.

"Insurable interest" is a term used in life insurance which also applies to this rule and is defined to be "such an interest in the life of the person insured, arising from the relations of the party obtaining the insurance, either as credit of or surety for the assured, or from the ties of blood or marriage to him, as would justify a reasonable expectation of advantage or benefit from the continuance of his life." *Warnock v. Davis,* 104 U.S. 775, 779, 26 L.Ed. 924; *Connecticut Mut. Life Ins. Co. v. Luchs,* 2 S.Ct. 949, 952, 108

U.S. 498, 27 L.Ed. 800; Appeal of Corson, 6 A. 213, 215, 113 Pa. 438, 57 Am. Rep. 479; *Adams' Adm'r v. Reed,* Ky., 36 S.W. 568, 570; *Trinity College v. Travelers' Co.,* 18 S.E. 175, 176, 113 N.C. 244, 22 L.R.A. 291; *Opitz v. Karel,* 95 N.W. 948, 951, 118 Wis. 527, 62 L.R.A. 982. It is not necessary that the expectation of advantage or profit should always be capable of pecuniary estimation, for a parent has an insurable interest in the life of his child, and a child in the life of his parent, a husband in the life of his wife, and a wife in the life of her husband. The natural affection in cases of this kind is considered as more powerful, as operating the more efficaciously, to protect the life of the insured than any other consideration, but in all cases there must be a reasonable ground, founded on relations to each other, either pecuniary or of blood or affinity, to expect some benefit or advantage from the continuance of the life of the assured. *Warnock v. Davis,* 104 U.S. 775, 26 L.Ed. 924; Appeal of Corson, 6 A. 213, 215, 113 Pa. 438, 57 Am. Rep. 479; *Connecticut Mut. Life Ins. Co. v. Luchs,* 2 S.Ct. 949, 952, 108 U.S. 498, 27 L.Ed. 800.

For purposes of this rule, the term "insurable interest" will be considered to apply to a beneficiary receiving retirement benefits due to the death of a pensioner or annuitant under the same circumstances as if the beneficiary were receiving life insurance benefits as a result of the death of the pensioner or annuitant.

For purposes of this rule, the term "survivor" is a person other than the surviving spouse of an annuitant or pensioner who is receiving the annuity or pension benefits because the person was a beneficiary of the pensioner or annuitant at the time of death of the pensioner or annuitant. In addition, in order for this person to qualify for the partial exclusion of pensions or retirement benefits, this survivor must have had an insurable interest in the pensioner or annuitant at the time of death of the annuitant or pensioner.

A survivor other than the surviving spouse will be considered to have an insurable interest in the pensioner or annuitant if the survivor is a son, daughter, mother, or father of the annuitant or pensioner. The relationship of these individuals to the pensioner or annuitant is considered to be so close that no separate pecuniary or monetary interest between the pensioner or annuitant and any of these relatives must be established.

A survivor may include relatives of the pensioner or annuitant other than those relatives that were mentioned above. However, before any of these relatives can be considered to be a survivor for purposes of this rule, the relative must have had some pecuniary interest in the continuation of the life of the pensioner or annuitant. That is, the relative must establish a relationship with the pensioner or annuitant that shows there was a reasonable expectation of an advantage or benefit which the person would have received with the continuance of the life of the pensioner or annuitant.

The fact that a niece of the pensioner or annuitant was named beneficiary of an uncle's pension where the uncle had no closer relatives does not in itself establish that the niece had an insurable interest in the pension benefits, if the niece was not receiving monetary benefits or the niece did not have some special relationship to the uncle at the time of the uncle's death.

If a grandson was receiving college tuition regularly from his grandfather and received the grandfather's pension as a beneficiary of the grandfather after the grandfather's death, the grandson would be deemed to have an insurable interest in the benefits and would be eligible for the partial retirement benefit exclusion.

A person who is not related to the pensioner or annuitant, such as a partner in a business or a creditor, may have an insurable interest in the pensioner or annuitant. However, the burden of proof is on a nonrelated person to show that the person had an insurable interest in the pensioner or the annuitant at the time of death of the pensioner or annuitant.

There are numerous court cases which deal with whether a person had established an insurable interest in the life of an individual that was insured. These cases may be used as a guideline to determine whether or not a person receiving a pension or annuity due to the death of an annuitant or pensioner had an insurable interest in the annuitant or pensioner at the time of death of the pensioner or annuitant. Thus, if a person would have met criteria for an insurable interest for purposes of an interest in a person's life insurance policy, the person would also be considered to be qualified for an insurable interest in a pensioner or annuitant.

Retirement benefits subject to the retirement income exclusion include, but are not limited to: benefits from defined benefit or defined contribution pension and annuity plans, benefits from annuities, incomes from individual retirement accounts, benefits from pension or annuity plans contributed by an employer or maintained or contributed by a self-employed person and benefits and earnings from deferred compensation plans. However, the exclusion does not apply to social security benefits. A surviving spouse who is not disabled or is not 55 years of age or older can only exclude retirement benefits received as a result of the death of the other spouse and on the basis that the deceased spouse would have been eligible for the exclusion in the tax year. In order for a survivor other than the surviving spouse to qualify for the partial exclusion of retirement benefits, the survivor must have received the retirement benefits as a result of the death of a pensioner or annuitant who would have qualified for the exclusion in the tax year on the basis of age or disability. In addition, the survivor other than the surviving spouse would have had to have an insurable interest in the pensioner or annuitant at the time of the death of the pensioner or annuitant.

For purposes of this rule, a disabled individual is a person who is receiving benefits as a result of retirement from employment or self-employment due to disability. In addition, a person is considered to be a disabled individual if the individual is determined to be disabled in accordance with criteria established by the Social Security Administration or other federal or state governmental agency.

Note that the pension or other retirement benefits that are excluded from taxation for certain individuals are to be considered as a part of net income for purposes of determining whether or not a particular individual's income is low enough to exempt that taxpayer from tax. In addition, the pension or other retirement benefits that are excluded from taxation for certain individuals are to be considered as a part of net income for the alternative tax computation, which is available to all taxpayers except those taxpayers filing as single individuals.

Finally, the pension or other retirement benefits are to be considered as a part of net income for individuals using the single filing status whose tax liabilities are limited so the liabilities cannot reduce the person's net income plus exempt benefits below $9,000, or below $18,000 for taxpayers 65 years of age or older for the 2007 and 2008 tax years, or below $24,000 for taxpayers 65 years of age or older for the 2009 and subsequent tax years.

This rule is intended to implement Iowa Code sections 422.5 and 422.7.

[**ARC 8605B**, IAB 3/10/10, effective 4/14/10]

701—40.48(422) Health insurance premiums deduction. For tax years beginning on or after January 1, 1996, the amounts paid by a taxpayer for health insurance for the taxpayer, the taxpayer's spouse, and the taxpayer's dependents are deductible in computing net income on the Iowa return to the extent the amounts paid were not otherwise deductible in computing adjusted gross income. However, amounts paid by a taxpayer for health insurance on a pretax basis whereby the portion of the wages of the taxpayer used to pay health insurance premiums is not included in the taxpayer's gross wages for income tax or social security tax purposes are not deductible on the Iowa return.

In situations where married taxpayers pay health insurance premiums from a joint checking or other joint account and the taxpayers are filing separate state returns or separately on the combined return form, the taxpayers must allocate the deduction between the spouses on the basis of the net income of each spouse to the combined net income unless one spouse can show that only that spouse's income was deposited to the joint account.

In circumstances where a taxpayer is self-employed and takes a deduction on the 1996 federal return for 30 percent of the premiums paid for health insurance on the federal return, the taxpayer would be allowed a deduction on the Iowa return for the portion of the health insurance premiums that was not deducted on the taxpayer's federal return, including any health insurance premiums deducted as an itemized medical deduction under Section 213 of the Internal Revenue Code.

For purposes of the state deduction for health insurance premiums, the same premiums for the same health insurance or medical insurance coverage qualify for this deduction as would qualify for the federal medical expense deduction. Thus, premiums paid for contact lens insurance qualify for the health insurance deduction. Also eligible for the deduction for tax years beginning in the 1996 calendar

year are premiums paid by a taxpayer before the age of 65 for medical care insurance effective after the age of 65, if the premiums are payable (on a level payment basis) for a period of ten years or more or until the year the taxpayer attains the age of 65 (but in no case for a period of less than five years). For tax years beginning on or after January 1, 1997, premiums for long-term health insurance for nursing home coverage are eligible for this deduction to the extent the premiums for long-term health care services are eligible for the federal itemized deduction for medical and dental expenses, irrespective of the limitations set forth in Section 213(d)(10) of the Internal Revenue Code. For example, a 55-year-old taxpayer who paid $1,050 in premiums for long-term health insurance for nursing home coverage for the 2004 tax year would be allowed a deduction for Iowa purposes for the entire $1,050, even though the limitation for the federal itemized deduction for medical expenses in Section 213(d)(10) of the Internal Revenue Code for these premiums for this taxpayer is $980.

Amounts paid under an insurance contract for other than medical care (such as payment for loss of limb or life or sight) are not deductible, unless the medical charge is stated separately in the contract or provided in a separate statement.

This rule is intended to implement Iowa Code section 422.7 as amended by 1997 Iowa Acts, Senate File 129.

701—40.49(422) Employer social security credit for tips. Employers in the food and beverage industry are allowed a credit under Section 45B of the Internal Revenue Code for a portion of the social security taxes paid or incurred after 1993 on employee tips. The credit is equal to the employer's FICA obligation attributable to tips received which exceed tips treated as wages for purposes of satisfying minimum wage standards of the Fair Labor Standards Act. The credit is allowed only for tips received by an employee in the course of employment from customers on the premises of a business for which the tipping of employees serving food or beverages is customary. To the extent that an employer takes the credit for a portion of the social security taxes paid or incurred, the employer's deduction for the social security tax is reduced accordingly. For Iowa income tax purposes, the full deduction for the social security tax paid or incurred is allowed for tax years beginning on or after January 1, 1994.

This rule is intended to implement Iowa Code Supplement section 422.7.

701—40.50(422) Computing state taxable amounts of pension benefits from state pension plans. For tax years beginning on or after January 1, 1995, a retired member of a state pension plan, or a beneficiary of a member, who receives benefits from the plan where there was a greater contribution to the plan for the member for state income tax purposes than for federal income tax purposes can report less taxable income from the benefits on the Iowa individual income tax return than was reported on the federal return for the same tax year. This rule applies only to a member of a state pension plan, or the beneficiary of a member, who received benefits from the plan sometime after January 1, 1995, and only in circumstances where the member received wages from public employment in 1995, 1996, 1997, or 1998, or possibly in 1999 for certain teachers covered by the state pension plan authorized in Iowa Code chapter 294 so the member had greater contributions to the state pension plan for state income tax purposes than for federal income tax purposes. Starting with wages paid on or after January 1, 1999, to employees covered by a state pension plan other than teachers covered by the state pension plan authorized in Iowa Code chapter 294, contributions made to the pension plan will be made on a pretax basis for state income tax purposes as well as for federal income tax purposes. However, in the case of teachers covered by the state pension plan authorized in Iowa Code chapter 294, contributions to the pension plan on behalf of these teachers on a pretax basis for state income tax purposes may start after January 1, 1999.

For example, in the case of a state employee who was covered by IPERS and had wages from covered public employment of $41,000 or more in 1995, that person would have made posttax contributions to IPERS of $1,517 for state income tax purposes for 1995 and zero posttax contributions to IPERS for federal income tax purposes for 1995. The $1,517 in contributions to IPERS for federal income tax purposes was made on a pretax basis and was considered to have been made by the employee's employer or the state of Iowa and not the employee. At the time this employee receives retirement benefits from

IPERS, the retired employee will be subject to federal income tax on the portion of the benefits that is attributable to the $1,517 IPERS contribution made in 1995. However, this employee will not be subject to state income tax on the portion of the IPERS benefits received which is attributable to the $1,517 contribution to IPERS for 1995.

This rule does not apply to members or beneficiaries of members who elect to take a lump sum distribution of benefits from a state pension plan in lieu of receiving monthly payments of benefits from the plan.

The following subrules further clarify how the portion of certain state pension benefits that is taxable for state individual income tax purposes for tax years beginning on or after January 1, 1995, is determined.

40.50(1) *Definitions related to state taxation of benefits from state pension plan.* The following definitions clarify those terms and phrases that have a bearing on the state's taxation of certain individuals who receive retirement benefits from state pension plans:

a. For purposes of this rule, the terms "state pension," "state pensions," and "state pension plans" mean only those pensions and those pension plans authorized in Iowa Code chapter 97A for public safety peace officers, chapter 97B for Iowa public employees (IPERS), chapter 294 for certain teachers, and chapter 411 for police officers and firefighters. There are other pension plans available for some public employees in the state which may be described as "state pensions" or "state pension plans" in other contexts or situations, but these pension plans are not covered by this rule. An example of a pension plan that is not a "state pension plan" for purposes of this rule is the judicial retirement system for state judges authorized in Iowa Code section 602.9101.

b. For purposes of this rule, "member" is an individual who was employed in public service covered by a state pension plan and is either receiving or was receiving benefits from the pension plan.

c. For purposes of this rule, "beneficiary" is a person who has received or is receiving benefits from a state pension plan due to the death of an individual or member who earned benefits in a state pension plan.

d. For purposes of this rule, the term "IPERS" means the Iowa public employees retirement system.

e. For purposes of this rule, the term "pretax," when the term is applied to a contribution made to a state pension plan during a year from a public employee's compensation, means a contribution to a state pension plan that is not taxed on the employee's income tax return for the tax year in which the contribution is made. The contribution is considered to have been made by the state or the employee's employer and not by the employee so this contribution is not part of the employee's basis in the pension that is not taxed when the pension is received.

f. For purposes of this rule, the term "posttax," when the term is applied to a contribution made to a state pension plan during a year from a public employee's compensation, means the contribution is included in the employee's taxable income for the tax year of the contribution and the contribution is considered to have been made by the employee. That is, the contribution is part of the employee's basis in the pension which is not taxed at the time the pension is received.

40.50(2) *Computation of the taxable amount of the state pension for federal income tax purposes.* An individual who receives benefits in the tax year from one of the state pension plans is not subject to federal income tax on the benefits to the extent of the pensioner's or member's recovery of posttax contribution to the pension plan. The individual receiving benefits in the year from a state pension plan should get a Form 1099-R showing the total benefits received in the tax year from the pension plan. The individual can determine the federal taxable amount of the benefits by using the general rule or the simplified general rule which is described in federal publication 17 or federal publication 575. Note that members who first receive pension benefits after November 18, 1996, must compute the federal taxable amount of their pension benefits by using the simplified general rule shown in the federal tax publications. Note also that individuals receiving benefits in the tax year from IPERS who started receiving benefits in 1993 or in later years will receive information with the 1099-R form which shows the amount of gross benefits received in the tax year that is taxable for federal income tax purposes.

40.50(3) *Computing the taxable amount of state pension benefits for state individual income tax purposes.* An individual receiving state pension benefits in the tax year must have a number of facts about the state pension in order to be able to compute the taxable amount of the pension for Iowa income tax purposes. The individual must know the gross pension benefits received in the tax year, the taxable amount of the pension for federal income tax purposes, the employee's contribution to the pension for federal income tax purposes, and the employee's contribution to the pension for state income tax purposes. In situations where the employee's contribution for state income tax purposes is equal to the contribution for federal income tax purposes, the same amount of the pension will be taxable on the state income tax return as is taxable on the federal return.

In cases when all of an individual's employment covered by a state pension plan occurred on or after January 1, 1995, so that all the contributions to the pension plan (other than posttax service purchases) for the employee were made on a pretax basis for federal income tax purposes, all of the benefits received from the pension would be taxed on the federal income tax return. In this situation, the state taxable amount of the pension would be computed using the general rule or the simplified general rule shown in federal publication 17 or federal publication 575. The employee's state contribution or state basis would be entered on line 2 of the worksheet in the federal publication that is usually used to compute the taxable amount of the pension for the federal income tax return.

To compute the state taxable amount of the state pension in situations where the employee had a contribution to the pension for federal tax purposes, the federal taxable amount for the year is first subtracted from the gross pension benefit received in the year which leaves the amount of the pension received in the year which was not taxable on the federal return. Next, the member's posttax contribution or basis in the pension for federal tax purposes is divided by the member's posttax contribution or basis in the pension for state income tax purposes which provides the ratio of the member's federal basis or contribution to the member's state contribution or basis. Next, the amount of the state pension received in the year that is not taxed on the federal return is divided by the ratio or percentage that was determined in the previous step, which provides the exempt amount of the pension for state tax purposes. Finally, the state exempt amount determined in the previous step is subtracted from the gross amount received in the year, which leaves the taxable amount for state income tax purposes. Note that individuals who retired in 1993 and in years after 1993 and are receiving benefits from IPERS will receive information from IPERS which will advise them of the taxable amount of the pension for state income tax purposes. The examples in subrule 40.50(4) are provided to illustrate how the state taxable amounts of state pension benefits received in the tax year are computed in different factual situations.

40.50(4) *Examples.*

a. A state employee retired in April 1996 and started receiving IPERS benefits in April 1996. The retired state employee received $1,794.45 in gross benefits from IPERS in 1996. The federal taxable amount of the benefits was $1,690.36. The employee's federal posttax contribution or basis in the pension was $4,907 and the state posttax contribution or basis was $7,194. The nontaxable amount of the IPERS benefits for federal income tax was $104.09 which was calculated by subtracting the federal taxable amount of $1,690.36 from the gross amount of the benefits of $1,794.45. The ratio of the employee's posttax contribution to the pension for federal income tax purposes was 68.21 percent of the employee's contribution to the pension for state income tax purposes. This was determined by dividing $4,907 by $7,194. The nontaxable amount of the IPERS benefit for federal income tax purposes of $104.09 was then divided by 68.21 percent, which is the ratio determined in the previous step, and which results in a total of $152.60. This was the nontaxable amount of the pension for state income tax purposes. When $152.60 is subtracted from the gross benefits of $1,794.45 paid in the year, the remaining amount is $1,641.85 which is the taxable amount of the pension that should be reported on the individual's Iowa individual income tax return for the 1996 tax year.

b. A state employee retired in July 1995. The retired employee received $1,881.88 in IPERS benefits in 1996 and $1,790.60 of the benefits was taxable on the individual's federal return for 1996. The person's federal posttax contribution to the IPERS pension was $3,130 and the posttax contribution for state income tax purposes was $3,821. The amount of benefits not taxable for federal income tax purposes was $91.28 which was computed by subtracting the amount of pension benefits of $1,790.60 that was

taxable on the federal income tax return from the gross benefits of $1,881.88 received in 1996. The retiree's federal posttax contribution of $3,130 to IPERS was divided by the retiree's posttax contribution of $3,821 to IPERS for state income tax purposes which resulted in a ratio of 81.91 percent. The amount of IPERS benefits of $91.28 exempt for federal income tax purposes is divided by the 81.91 percent computed in the previous step which results in an amount of $111.44 which is the amount of IPERS benefits received in 1996 which is not taxable on the Iowa return. $111.44 is subtracted from the gross benefits of $1,881.88 received in 1996 which leaves the state taxable amount for 1996 of $1,770.44.

This rule is intended to implement Iowa Code section 422.7 as amended by 1998 Iowa Acts, House File 2513.

701—40.51(422) Exemption of active-duty military pay of national guard personnel and armed forces military reserve personnel for overseas services pursuant to military orders for peacekeeping in the Bosnia-Herzegovina area. For active duty military pay received on or after November 21, 1995, by national guard personnel and by armed forces military reserve personnel, the pay is exempt from state income tax to the extent the military pay was earned overseas for services performed pursuant to military orders related to peacekeeping in the Bosnia-Herzegovina area. In order for the active duty pay to qualify for exemption from tax, the military service had to have been performed outside the United States, but not necessarily in the Bosnia-Herzegovina area.

This rule is intended to implement Iowa Code section 422.7 as amended by 1997 Iowa Acts, House File 355.

701—40.52(422) Mutual funds. Iowa does not tax dividend or interest income from regulated investment companies to the extent that such income is derived from interest on United States Government obligations or obligations of this state and its political subdivisions. The exemption is also applicable to income from regulated investment companies which is derived from interest on government-sponsored enterprises and agencies where federal law specifically precludes state taxation of such interest. Income derived from interest on securities which are merely guaranteed by the federal government or from repurchase agreements collateralized by the United States Government obligations is not excluded and is subject to Iowa income tax. There is no distinction between Iowa's tax treatment of interest received by a direct investor as compared with a mutual fund shareholder. The interest retains its same character when it "flows-through" the mutual fund and is subject to taxation accordingly.

Taxpayers may subtract from federal adjusted gross income, income received from any of the obligations listed in 701—subrule 40.2(1) and rule 701—40.3(422) above, even if the obligations are owned indirectly through owning shares in a mutual fund:

1. If the fund invests exclusively in these state tax-exempt obligations, the entire amount of the distribution (income) from the fund may be subtracted.
2. If the fund invests in both exempt and nonexempt obligations, the amount represented by the percentage of the distribution that the mutual fund identifies as exempt may be subtracted.
3. If the mutual fund does not identify an exempt amount or percentage, taxpayers may figure the amount to be subtracted by multiplying the distribution by the following fraction: as the numerator, the amount invested by the fund in state-exempt United States obligations; as the denominator, the fund's total investment. Use the year-end amounts to figure the fraction if the percentage ratio has remained constant throughout the year. If the percentage ratio has not remained constant, take the average of the ratios from the fund's quarterly financial reports.

Therefore, if the federal adjusted gross income of an individual, taxable by Iowa, includes dividends or interest of this type, an adjustment must be made deducting the amount of the dividend or interest.

This rule is intended to implement Iowa Code section 422.7.

701—40.53(422) Deduction for contributions by taxpayers to the Iowa educational savings plan trust and addition to income for refunds of contributions previously deducted. The Iowa educational savings plan trust was created so that individuals can contribute funds on behalf of beneficiaries in accounts administered by the treasurer of state to cover future higher education costs

of the beneficiaries. The Iowa educational savings plan trust includes the college savings Iowa plan and the Iowa advisor 529 plan. The following subrules provide details on how individuals' net incomes are affected by contributions to beneficiaries' accounts, interest and any other earnings earned on beneficiaries' accounts, and refunds of contributions which were previously deducted.

40.53(1) *Deduction from net income for contributions made to the Iowa educational savings plan trust on behalf of beneficiaries.* Effective with contributions made on or after July 1, 1998, an individual referred to as a "participant" can claim a deduction on the Iowa individual income tax return for contributions made by that individual to the Iowa educational savings plan trust on behalf of a beneficiary. The deduction on the 1998 Iowa return cannot exceed $2,000 per beneficiary for contributions made in 1998 or the adjusted maximum annual amount for contributions made after 1998. Note that the maximum annual amount that can be deducted per beneficiary may be adjusted or increased to an amount greater than $2,000 for inflation on an annual basis. Rollover contributions from other states' educational savings plans will qualify for the deduction, subject to the maximum amount allowable. Starting with tax years beginning in the 2000 calendar year, a participant may contribute an amount on behalf of a beneficiary that is greater than $2,000, but may claim a deduction on the Iowa individual return of the lesser of the amount given or $2,000 as adjusted by inflation. For example, if a taxpayer made a $5,000 contribution on behalf of a beneficiary to the educational savings plan in 2000, the taxpayer may claim a deduction on the IA 1040 return for 2000 in the amount of $2,054, as this amount is $2,000 as adjusted for inflation in effect for 2000.

For example, an individual has ten grandchildren from the age of six months to 12 years. In October 1998, the person became a participant in the Iowa educational savings plan trust by making $2,000 contributions to the trust on behalf of each of the ten grandchildren. When the participant files the 1998 Iowa individual income tax return, the participant can claim a deduction on the return for the $20,000 contributed to the Iowa educational savings plan trust on behalf of the individual's ten grandchildren.

40.53(2) *Exclusion of interest and earnings on beneficiary accounts in the Iowa educational savings plan trust.* To the extent that interest or other earnings accrue on a beneficiary's account in the Iowa educational savings plan trust, the interest or other earnings are excluded for purposes of computing net income on the Iowa individual income tax return of the participant or the return of the beneficiary.

40.53(3) *Including on the Iowa individual return amounts refunded to the participant from the Iowa educational savings plan trust that had previously been deducted.* If a participant cancels a beneficiary's account in the Iowa educational savings plan trust and receives a refund of the funds in the account made on behalf of the beneficiary, or if a participant makes a withdrawal from the Iowa educational savings plan trust for purposes other than the payment of qualified education expenses, the refund of the funds is to be included in net income on the participant's Iowa individual income tax return to the extent that contributions to the account had been deducted on prior state individual income tax returns of the participant.

For example, because a beneficiary of a certain participant died in the year 2000, this participant in the Iowa educational savings plan trust canceled the participant agreement for the beneficiary with the trust and received a refund of $4,200 of funds in the beneficiary's account. Because $4,000 of the refund represented contributions that the participant had deducted on prior Iowa individual income tax returns, the participant was to report on the Iowa return for the tax year 2000, $4,000 in contributions that had been deducted on the participant's Iowa returns for 1998 and 1999.

40.53(4) *Deduction for contributions made to the endowment fund of the Iowa educational savings plan trust.* To the extent that the contribution was not deductible for federal income tax purposes, an individual can deduct on the Iowa individual income tax return a gift, grant, or donation to the endowment fund of the Iowa educational savings plan trust. The contribution must be made on or after July 1, 1998, but before April 15, 2004. Effective April 15, 2004, the deduction for contributions made to the endowment fund is repealed.

This rule is intended to implement Iowa Code section 422.7 as amended by 2007 Iowa Acts, House File 923.

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701—40.54(422) Roth individual retirement accounts. Roth individual retirement accounts were authorized in the Taxpayer Relief Act of 1997 and are applicable for tax years beginning after December 31, 1997. Generally, no deduction is allowed on either the federal income tax return or the Iowa individual income tax return for a contribution to a Roth IRA. The following subrules include information about tax treatment of certain transactions for Roth IRAs.

40.54(1) *Taxation of income derived from rolling over or converting existing IRAs to Roth IRAs.* At the time existing IRAs are rolled over to or converted to Roth IRAs in the 1998 calendar year or in a subsequent year, any income realized from the rollover or conversion of the existing IRA is taxable. However, in the case of conversion of existing IRAs to Roth IRAs in 1998, the taxpayer can make an election to have all the income realized from the conversion subject to tax in 1998 rather than have the conversion income spread out over four years. If the conversion income is spread out over four years, one-fourth of the conversion income is included on the 1998 Iowa and federal returns of the taxpayer and one-fourth of the income is included on the taxpayer's Iowa and federal returns for each of the following three tax years. Note that if an existing IRA for an individual is converted to a Roth IRA for the individual in a calendar year after 1998, all the income realized from the conversion is to be reported on the federal return and the Iowa return for that tax year for the individual. That is, when conversion of existing IRAs to Roth IRAs occurs after 1998, there is no provision for having the conversion income taxed over four years.

For example, an Iowa resident converted three existing IRAs to one Roth IRA in 1998, realized $20,000 in income from the conversion, and did not elect to have all the conversion income taxed on the 1998 Iowa and federal returns. Because the taxpayer did not make the election so all the conversion income was taxed in 1998, $5,000 in conversion income was to be reported on the taxpayer's federal and Iowa returns for 1998 and similar incomes were to be reported on the federal and Iowa returns for 1999, 2000, and 2001. Note that to the extent the recipient of the Roth IRA conversion income is eligible, the conversion income is subject to the pension/retirement income exclusion described in rule 701—40.47(422).

40.54(2) *Roth IRA conversion income for part-year residents.* To the extent that an Iowa resident has Roth IRA conversion income on the individual's federal income tax return, the same income will be included on the resident's Iowa income tax return. However, when an individual with Roth IRA conversion income in the tax year is a part-year resident of Iowa, the individual may allocate the conversion income on the Iowa return in the ratio of the taxpayer's months in Iowa during the tax year to 12 months. In a situation where an individual spends more than half of a month in Iowa, that month is to be reported to Iowa for purposes of the allocation.

For example, an individual moved to Des Moines from Omaha on June 12, 1998, and had $20,000 in Roth IRA conversion income in 1998. Because the individual spent 7 months in Iowa in 1998, 7/12, or 60 percent, of the $20,000 in conversion income is allocated to Iowa. Thus, $12,000 of the conversion income should be reported on the taxpayer's Iowa return for 1998.

This rule is intended to implement Iowa Code section 422.7 as amended by 1998 Iowa Acts, Senate File 2357.

701—40.55(422) Exemption of income payments for victims of the Holocaust and heirs of victims. For tax years beginning on or after January 1, 2000, income payments received by individuals because they were victims of the Holocaust or income payments received by individuals who are heirs of victims of the Holocaust are excluded in the computation of net incomes, to the extent the payments were included in the individuals' federal adjusted gross incomes. Victims of the Holocaust were victims of persecution in the World War II era for racial, ethnic or religious reasons by Nazi Germany or other Axis regime.

Holocaust victims may receive income payments for slave labor performed in the World War II era. Income payments may also be received by Holocaust victims as reparation for assets stolen from, hidden from, or otherwise lost in the World War II era, including proceeds from insurance policies of the victims. The World War II era includes the time of the war and the time immediately before and immediately after the war. However, income from assets acquired with the income payments or from

the sale of those assets shall not be excluded from the computation of net income. The exemption of income payments shall only apply to the first recipient of the income payments who was either a victim of persecution by Nazi Germany or any other Axis regime or a person who is an heir of the victim of persecution.

This rule is intended to implement Iowa Code sections 217.39 and 422.7.

701—40.56(422) Taxation of income from the sale of obligations of the state of Iowa and its political subdivisions. For tax years beginning on or after January 1, 2001, income from the sale of obligations of the state of Iowa and its political subdivisions shall be added to Iowa net income to the extent not already included. Gains or losses from the sale or other disposition of bonds issued by the state of Iowa or its political subdivisions shall be included in Iowa net income unless the law authorizing these obligations specifically exempts the income from the sale or other disposition of the bonds from the Iowa individual income tax.

This rule is intended to implement Iowa Code section 422.7 as amended by 2001 Iowa Acts, chapter 116.

701—40.57(422) Installment sales by taxpayers using the accrual method of accounting. For tax years beginning on or after January 1, 2000, and prior to January 1, 2002, taxpayers who use the accrual method of accounting and who have sales or exchanges of property that they reported on the installment method for federal income tax purposes must report the total amount of the gain or loss from the transaction in the tax year of the sale or exchange pursuant to Section 453 of the Internal Revenue Code as amended up to and including January 1, 2000.

EXAMPLE 1. Taxpayer Jones uses the accrual method of accounting for reporting income. In 2001, Mr. Jones sold farmland he had held for eight years for $200,000 which resulted in a capital gain of $50,000. For federal income tax purposes, Mr. Jones elected to report the transaction on the installment basis, where he reported $12,500 of the gain on his 2001 federal return and will report capital gains of $12,500 on each of his federal returns for the 2002, 2003 and 2004 tax years.

However, for Iowa income tax purposes, Mr. Jones must report on his 2001 Iowa return the entire capital gain of $50,000 from the land sale. Although Taxpayer Jones must report a capital gain of $12,500 on each of his federal income tax returns for 2002, 2003 and 2004, from the installment sale of the farmland in 2001, he will not have to include the installments of $12,500 on his Iowa income tax returns for those three tax years because Mr. Jones had reported the entire capital gain of $50,000 from the 2001 transaction on his 2001 Iowa income tax return.

EXAMPLE 2. Taxpayer Smith uses the accrual method of accounting for reporting income. In 2002, Mr. Smith sold farmland he had held for eight years for $500,000 which resulted in a capital gain of $100,000. For federal income tax purposes, Mr. Smith elected to report the transaction on the installment basis, where he reported $20,000 of the gain on his 2002 federal return and will report the remaining capital gains on federal returns for the four subsequent tax years. Because this installment sale occurred in 2002, Mr. Smith shall report $20,000 of the capital gain on his Iowa income tax return for 2002 and will report the balance of the capital gains from the installment sale on Iowa returns for the next four tax years, the same as reported on his federal returns for those years.

This rule is intended to implement Iowa Code section 422.7 as amended by 2002 Iowa Acts, House File 2116.

701—40.58(422) Exclusion of distributions from retirement plans by national guard members and members of military reserve forces of the United States. For tax years beginning on or after January 1, 2002, members of the Iowa national guard or members of military reserve forces of the United States who are ordered to state military service or federal service or duty are not subject to Iowa income tax on the amount of distributions received during the tax year from qualified retirement plans of the members to the extent the distributions were taxable for federal income tax purposes. In addition, the members are not subject to state penalties on the distributions even though the members may have been subject to federal penalties on the distributions for early withdrawal of benefits. Because the distributions described

above are not taxable for Iowa income tax purposes, a national guard member or armed forces reserve member who receives a distribution from a qualified retirement plan may request that the payer of the distribution not withhold Iowa income tax from the distribution.

This rule is intended to implement Iowa Code section 422.7 as amended by 2004 Iowa Acts, House File 2208.

701—40.59(422) Exemption of payments received by a beneficiary from an annuity purchased under an employee's retirement plan when the installment has been included as part of a decedent employee's estate. All payments received on or after July 1, 2002, by a beneficiary of a deceased pensioner or annuitant are exempt from Iowa income tax to the extent the payments are from an annuity purchased under an employee's pension or retirement plan when the commuted value of the installments has been included as a part of the decedent employee's estate for Iowa inheritance tax purposes. Thus, a lump sum payment received by a beneficiary from an annuity purchased under an employee's pension or retirement plan is exempt from Iowa income tax to the extent the commuted value of the annuity was included as part of the decedent employee's estate for Iowa inheritance tax purposes. Under prior law, only installment payments of an annuity received by a beneficiary were exempt from Iowa income tax if the commuted value of the installments had been included as part of the decedent employee's estate for Iowa inheritance tax purposes.

This rule is intended to implement Iowa Code section 422.7 as amended by 2002 Iowa Acts, Senate File 2305.

701—40.60(422) Additional first-year depreciation allowance.

40.60(1) *Assets acquired after September 10, 2001, but before May 6, 2003.* For tax periods ending after September 10, 2001, but beginning before May 6, 2003, the additional first-year depreciation allowance ("bonus depreciation") of 30 percent authorized in Section 168(k) of the Internal Revenue Code, as enacted by Public Law No. 107-147, Section 101, does not apply for Iowa individual income tax. Taxpayers who claim the bonus depreciation on their federal income tax return must add the total amount of depreciation claimed on assets acquired after September 10, 2001, but before May 6, 2003, and subtract the amount of depreciation taken on such property using the modified accelerated cost recovery system (MACRS) depreciation method applicable under Section 168 of the Internal Revenue Code without regard to Section 168(k).

If any such property was sold or disposed of during the tax year, the applicable depreciation catch-up adjustment must be made to adjust the basis of the property for Iowa tax purposes. The gain or loss reported on the sale or disposition of these assets for federal tax purposes must be adjusted for Iowa tax purposes to account for the adjusted basis of assets.

The adjustment for both depreciation and the gain or loss on the sale of qualifying assets acquired after September 10, 2001, but before May 6, 2003, can be calculated on Form IA 4562A.

See 701—subrule 53.22(1) for examples illustrating how this subrule is applied.

40.60(2) *Assets acquired after May 5, 2003, but before January 1, 2005.* For tax periods beginning after May 5, 2003, but beginning before January 1, 2005, the bonus depreciation of 50 percent authorized in Section 168(k) of the Internal Revenue Code, as amended by Public Law No. 108-27, Section 201, may be taken for Iowa individual income tax. If the taxpayer elects to take the 50 percent bonus depreciation, the depreciation deduction allowed on the Iowa individual income tax return is the same as the depreciation deduction allowed on the federal income tax return for assets acquired after May 5, 2003, but before January 1, 2005.

a. If the taxpayer elects to take the 50 percent bonus depreciation and had filed an Iowa return prior to February 24, 2005, which reflected the disallowance of 50 percent bonus depreciation, the taxpayer may choose between two options to reflect this change. Taxpayer may either file an amended return for the applicable tax year to reflect the 50 percent bonus depreciation provision, or taxpayer may reflect the change for 50 percent bonus depreciation on the next Iowa return filed subsequent to February 23, 2005. Taxpayer must choose only one of these two options. Regardless of the option chosen, taxpayer must

complete and attach a revised Form IA 4562A to either the amended return or the return filed subsequent to February 23, 2005.

EXAMPLE 1: Taxpayer filed a 2003 Iowa individual income tax return on April 15, 2004, which reflected an adjustment of $50,000 for the difference between federal depreciation and Iowa depreciation relating to the disallowance of 50 percent bonus depreciation. Taxpayer now elects to take the 50 percent bonus depreciation for Iowa tax purposes. Taxpayer may either amend the 2003 Iowa return to reflect a $50,000 reduction in Iowa taxable income, or taxpayer may take the additional deduction of $50,000 on taxpayer's 2004 Iowa return that is filed after February 23, 2005.

EXAMPLE 2: Assume the same facts as given in Example 1, and taxpayer filed a 2004 Iowa return prior to February 24, 2005. Taxpayer did not take an additional $50,000 deduction on the 2004 Iowa return. Taxpayer may either amend the 2003 Iowa return to reflect a $50,000 reduction in Iowa taxable income, or taxpayer may take the additional deduction of $50,000 on taxpayer's 2005 Iowa return.

b. If the taxpayer elects not to take the 50 percent bonus depreciation, taxpayer must add the total amount of depreciation claimed on assets acquired after May 5, 2003, but before January 1, 2005, and subtract the amount of depreciation taken on such property using the modified accelerated cost recovery system (MACRS) depreciation method applicable under Section 168 of the Internal Revenue Code without regard to Section 168(k). If any such property was sold or disposed of during the tax year, the applicable depreciation catch-up adjustment must be made to adjust the basis of the property for Iowa tax purposes. The gain or loss reported on the sale or disposition of these assets for federal tax purposes must be adjusted for Iowa tax purposes to account for the adjusted basis of assets. The adjustment for both depreciation and the gain or loss on the sale of qualifying assets acquired after May 5, 2003, but before January 1, 2005, can be calculated on Form IA 4562A.

40.60(3) *Assets acquired after December 31, 2007, but before January 1, 2010.* For tax periods beginning after December 31, 2007, but beginning before January 1, 2010, the bonus depreciation of 50 percent authorized in Section 168(k) of the Internal Revenue Code, as amended by Public Law No. 110-185, Section 103, and Public Law 111-5, Section 1201, does not apply for Iowa individual income tax. Taxpayers who claim the bonus depreciation on their federal income tax return must add the total amount of depreciation claimed on assets acquired after December 31, 2007, but before January 1, 2010, and subtract the amount of depreciation taken on such property using the modified accelerated cost recovery system (MACRS) depreciation method applicable under Section 168 of the Internal Revenue Code without regard to Section 168(k).

If any such property was sold or disposed of during the tax year, the applicable depreciation catch-up adjustment must be made to adjust the basis of the property for Iowa tax purposes. The gain or loss reported on the sale or disposition of these assets for federal tax purposes must be adjusted for Iowa tax purposes to account for the adjusted basis of assets.

The adjustment for both depreciation and the gain or loss on the sale of qualifying assets acquired after December 31, 2007, but before January 1, 2010, can be calculated on Form IA 4562A.

See rule 701—53.22(422) for examples illustrating how this rule is applied.

40.60(4) *Qualified disaster assistance property.* For property placed in service after December 31, 2007, with respect to federal declared disasters occurring before January 1, 2010, the bonus depreciation of 50 percent authorized in Section 168(n) of the Internal Revenue Code for qualified disaster assistance property, as amended by Public Law 110-343, Section 710, does not apply for Iowa individual income tax. Taxpayers who claim the bonus depreciation on their federal income tax return must add the total amount of depreciation claimed on qualified disaster assistance property and subtract the amount of depreciation taken on such property using the modified accelerated cost recovery system (MACRS) depreciation method applicable under Section 168 of the Internal Revenue Code without regard to Section 168(n).

If any such property was sold or disposed of during the tax year, the applicable depreciation catch-up adjustment must be made to adjust the basis of the property for Iowa tax purposes. The gain or loss reported on the sale or disposition of this property for federal tax purposes must be adjusted for Iowa tax purposes to account for the adjusted basis of such property.

The adjustment for both depreciation and the gain or loss on the sale of qualifying disaster assistance property can be calculated on Form IA 4562A.

40.60(5) *Assets acquired after December 31, 2009, but before January 1, 2013.* For tax periods beginning after December 31, 2009, but beginning before January 1, 2013, the bonus depreciation authorized in Section 168(k) of the Internal Revenue Code, as amended by Public Law No. 111-240, Section 2022, and Public Law No. 111-312, Section 401, does not apply for Iowa individual income tax. Taxpayers who claim the bonus depreciation on their federal income tax return must add the total amount of depreciation claimed on assets acquired after December 31, 2009, but before January 1, 2013, and subtract the amount of depreciation taken on such property using the modified accelerated cost recovery system (MACRS) depreciation method applicable under Section 168 of the Internal Revenue Code without regard to Section 168(k).

If any such property was sold or disposed of during the tax year, the applicable depreciation catch-up adjustment must be made to adjust the basis of the property for Iowa tax purposes. The gain or loss reported on the sale or disposition of these assets for federal tax purposes must be adjusted for Iowa tax purposes to account for the adjusted basis of assets.

The adjustment for both depreciation and the gain or loss on the sale of qualifying assets acquired after December 31, 2009, but before January 1, 2013, can be calculated on Form IA 4562A.

See 701—subrule 53.22(3) for examples illustrating how this subrule is applied.

This rule is intended to implement Iowa Code section 422.7 as amended by 2011 Iowa Acts, Senate File 512.

[**ARC 8589B**, IAB 3/10/10, effective 4/14/10; **ARC 9820B**, IAB 11/2/11, effective 12/7/11]

701—40.61(422) Exclusion of active duty pay of national guard members and armed forces military reserve members for service under orders for Operation Iraqi Freedom, Operation Noble Eagle, Operation Enduring Freedom or Operation New Dawn. For tax years beginning on or after January 1, 2003, active duty pay received by national guard members and armed forces reserve members is excluded to the extent the income is included in federal adjusted gross income and to the extent the active duty pay is for service under military orders for Operation Iraqi Freedom, Operation Noble Eagle or Operation Enduring Freedom. For tax years beginning on or after January 1, 2010, active duty pay received by national guard members and armed forces reserve members is excluded to the extent the income is included in federal adjusted gross income and to the extent the active duty pay is for service under military orders for Operation New Dawn. National guard members and military reserve members receiving active duty pay on or after January 1, 2003, but before January 1, 2011, for service not covered by military orders for one of the operations specified above are subject to Iowa income tax on the active duty pay to the extent the active duty pay is included in federal adjusted gross income. For active duty pay received on or after January 1, 2011, see rule 701—40.76(422). An example of a situation where the active duty pay may not be included in federal adjusted gross income is when the active duty pay was received for service in an area designated as a combat zone or in an area designated as a hazardous duty area so the income may be excluded from federal adjusted gross income. That is, if an individual's active duty military pay is not subject to federal income tax, the active duty military pay will not be taxable on the individual's Iowa income tax return.

National guard members and military reserve members who are receiving active duty pay for service on or after January 1, 2003, that is exempt from Iowa income tax, may complete an IA W-4 Employee Withholding Allowance Certificate and claim exemption from Iowa income tax for active duty pay received during the time they are serving on active duty pursuant to military orders for Operation Iraqi Freedom, Operation Noble Eagle, Operation Enduring Freedom or Operation New Dawn.

This rule is intended to implement Iowa Code section 422.7 as amended by 2011 Iowa Acts, House File 652.

[**ARC 9822B**, IAB 11/2/11, effective 12/7/11]

701—40.62(422) Deduction for overnight expenses not reimbursed for travel away from home of more than 100 miles for performance of service as a member of the national guard or armed forces military reserve. A taxpayer may subtract, in computing net income, the costs not reimbursed that were

incurred for overnight transportation, meals and lodging expenses for travel away from the taxpayer's home more than 100 miles, to the extent the travel expenses were incurred for the performance of services on or after January 1, 2003, by the taxpayer as a national guard member or an armed forces military reserve member. The deduction for Iowa tax purposes is the same that is allowed for federal income tax purposes.

This rule is intended to implement Iowa Code section 422.7 as amended by 2005 Iowa Acts, House File 186.

701—40.63(422) Exclusion of income from military student loan repayments. Individuals serving on active duty in the national guard, armed forces military reserve or the armed forces of the United States may subtract, to the extent included in federal adjusted gross income, income from military student loan repayments made on or after January 1, 2003.

This rule is intended to implement Iowa Code section 422.7 as amended by 2003 Iowa Acts, House File 674.

701—40.64(422) Exclusion of death gratuity payable to an eligible survivor of a member of the armed forces, including a member of a reserve component of the armed forces who has died while on active duty. An eligible survivor of a member of the armed forces, including a member of a reserve component of the armed forces, who has died while on active duty may subtract, to the extent included in federal adjusted gross income, a gratuity death payment made to the eligible survivor of a member of the armed forces who died while on active duty after September 10, 2001. This exclusion applies to a gratuity death payment made to the eligible survivor of any person in the armed forces or a reserve component of the armed forces who died while on active duty after September 10, 2001.

The purpose of the death gratuity is to provide a cash payment to assist a survivor of a deceased member of the armed forces to meet financial needs during the period immediately following a service member's death and before other survivor benefits, if any, become available.

This rule is intended to implement Iowa Code section 422.7 as amended by 2003 Iowa Acts, House File 674.

701—40.65(422) Section 179 expensing. For tax periods beginning on or after January 1, 2003, but beginning before January 1, 2006, the increase in the expensing allowance for qualifying property authorized in Section 179(b) of the Internal Revenue Code, as enacted by Public Law No. 108-27, Section 202, may be taken for Iowa individual income tax. If the taxpayer elects to take the increased Section 179 expensing, the Section 179 expensing allowance on the Iowa individual income tax return is the same as the Section 179 expensing allowance on the federal income tax return for tax years beginning on or after January 1, 2003, but beginning before January 1, 2006. In addition, for tax periods beginning on or after January 1, 2008, but beginning before January 1, 2009, the increase in the expensing allowance for qualifying property authorized in Section 179(b) of the Internal Revenue Code, as enacted by Public Law No. 110-185, Section 102, may be taken for Iowa individual income tax. For tax periods beginning on or after January 1, 2009, but beginning before January 1, 2010, the increase in the expensing allowance for qualifying property authorized in Section 179(b) of the Internal Revenue Code, as enacted by Public Law No. 111-5, Section 1202, cannot be taken for Iowa individual income tax purposes. The maximum amount of Section 179 expensing allowed for tax periods beginning on or after January 1, 2009, but beginning before January 1, 2010, is $133,000 for Iowa individual income tax purposes. For tax years beginning on or after January 1, 2010, the increase in the expensing allowance for qualifying property authorized in Section 179(b) of the Internal Revenue Code, as enacted by Public Law No. 111-240, Section 2021, and Public Law No. 111-312, Section 402, may be taken for Iowa individual income tax.

40.65(1) If the taxpayer elects to take the increased Section 179 expensing and had filed an Iowa return prior to February 24, 2005, which reflected the disallowance of increased Section 179 expensing, the taxpayer may choose between two options to reflect this change. Taxpayer may either file an amended return for the applicable tax year to reflect the increased Section 179 expensing, or taxpayer may reflect

the change for increased Section 179 expensing on the next Iowa return filed subsequent to February 23, 2005. Taxpayer must choose only one of these two options. Regardless of the option chosen, taxpayer must complete and attach a revised Form IA 4562A to either the amended return or the return filed subsequent to February 23, 2005.

EXAMPLE 1: Taxpayer filed a 2003 Iowa individual income tax return on April 15, 2004, which reflected an adjustment of $50,000 for the difference between the federal Section 179 expensing allowance and the Iowa Section 179 expensing allowance. Taxpayer now elects to take the increased Section 179 expensing allowance for Iowa tax purposes. Taxpayer may either amend the 2003 Iowa return to reflect a $50,000 reduction in Iowa taxable income, or taxpayer may take the additional deduction of $50,000 on taxpayer's 2004 Iowa return that is filed after February 23, 2005.

EXAMPLE 2: Assume the same facts as given in Example 1, and taxpayer filed a 2004 Iowa return prior to February 24, 2005. Taxpayer did not take an additional $50,000 deduction on the 2004 Iowa return. Taxpayer may either amend the 2003 Iowa return to reflect a $50,000 reduction in Iowa taxable income, or taxpayer may take the additional deduction of $50,000 on taxpayer's 2005 Iowa return.

40.65(2) If the taxpayer elects not to take the increased Section 179 expensing, the expensing allowance is limited to $25,000 for Iowa tax purposes. The difference between the federal Section 179 expensing allowance on such property, if in excess of $25,000, and the Iowa expensing allowance of $25,000 can be depreciated using the modified accelerated cost recovery system (MACRS) applicable under Section 168 of the Internal Revenue Code without regard to the bonus depreciation provision in Section 168(k).

If any such property was sold or disposed of during the tax year, the applicable Section 179 and related depreciation catch-up adjustment must be made to adjust the basis of the property for Iowa tax purposes. The gain or loss reported on the sale or disposition of these assets for federal tax purposes must be adjusted for Iowa tax purposes to account for the adjusted basis of assets.

The adjustment for both the Section 179 expensing allowance and related depreciation, along with the gain or loss on the sale of qualifying assets for tax years beginning on or after January 1, 2003, but beginning before January 1, 2006, can be calculated on Form IA 4562A.

See 701—subrule 53.23(2) for examples illustrating how this subrule is applied.

This rule is intended to implement Iowa Code section 422.7 as amended by 2011 Iowa Acts, Senate File 512.

[**ARC 9103B**, IAB 9/22/10, effective 10/27/10; **ARC 9820B**, IAB 11/2/11, effective 12/7/11]

701—40.66(422) Deduction for certain unreimbursed expenses relating to a human organ transplant. For tax years beginning on or after January 1, 2005, a taxpayer, while living, may subtract up to $10,000 in unreimbursed expenses that were incurred relating to the taxpayer's donation of all or part of a liver, pancreas, kidney, intestine, lung or bone marrow to another human being for immediate human organ transplantation. The taxpayer can claim this deduction only once, and the deduction can be claimed in the year in which the transplant occurred. The unreimbursed expenses must not be compensated by insurance to qualify for the deduction.

The unreimbursed expenses which are eligible for the deduction include travel expenses, lodging expenses and lost wages. If the deduction is claimed for travel expenses and lodging expenses, these expenses cannot also be claimed as an itemized deduction for medical expenses under Section 213(d) of the Internal Revenue Code for Iowa tax purposes. The deduction for lost wages does not include any sick pay or vacation pay reimbursed by an employer.

This rule is intended to implement Iowa Code section 422.7 as amended by 2005 Iowa Acts, House File 801.

701—40.67(422) Deduction for alternative motor vehicles. For tax years beginning on or after January 1, 2006, but beginning before January 1, 2015, a taxpayer may subtract $2,000 for the cost of a clean fuel motor vehicle if the taxpayer was eligible to claim for federal tax purposes the alternative motor vehicle credit under Section 30B of the Internal Revenue Code for this motor vehicle.

The vehicles eligible for this deduction include new qualified fuel cell motor vehicles, new advanced lean burn technology motor vehicles, new qualified hybrid motor vehicles, qualified plug-in electric drive motor vehicles and new qualified alternative fuel vehicles. The advanced lean burn technology, qualified hybrid and qualified alternative fuel vehicles must be placed in service before January 1, 2011, to qualify for the deduction. The qualified plug-in electric drive motor vehicles must be placed in service before January 1, 2012, to qualify for the deduction. The qualified fuel cell motor vehicles must be placed in service before January 1, 2015, to qualify for the deduction. A taxpayer must claim a credit on the taxpayer's federal income tax return on federal Form 8910 to claim the deduction on the Iowa return.

This rule is intended to implement Iowa Code section 422.7.

[**ARC 9820B**, IAB 11/2/11, effective 12/7/11]

701—40.68(422) Injured veterans grant program.

40.68(1) For tax years beginning on or after January 1, 2006, a taxpayer who receives a grant under the injured veterans grant program provided in 2006 Iowa Acts, Senate File 2312, section 1, may subtract, to the extent included in federal adjusted gross income, the amount of the grant received. The injured veterans grant program is administered by the Iowa department of veterans affairs, and grants of up to $10,000 are provided to veterans who are residents of Iowa and are injured in the line of duty in a combat zone or in a zone where the veteran was receiving hazardous duty pay after September 11, 2001.

40.68(2) For tax years beginning on or after January 1, 2006, a taxpayer may subtract, to the extent not otherwise deducted in computing adjusted gross income, the amounts contributed to the department of veterans affairs for the purpose of providing grants under the injured veterans grant program established in 2006 Iowa Acts, Senate File 2312, section 1. If a deduction is claimed for these amounts contributed to the injured veterans grant program, this deduction cannot also be claimed as an itemized deduction for charitable contributions under Section 170 of the Internal Revenue Code for Iowa tax purposes.

This rule is intended to implement Iowa Code section 422.7 as amended by 2006 Iowa Acts, Senate File 2312.

701—40.69(422) Exclusion of ordinary or capital gain income realized as a result of involuntary conversion of property due to eminent domain. For tax years beginning on or after January 1, 2006, a taxpayer may exclude the amount of ordinary or capital gain income realized as a result of the involuntary conversion of property due to eminent domain for Iowa individual income tax. Eminent domain refers to the authority of government agencies or instrumentalities of government to requisition or condemn private property for any public improvement, public purpose or public use. The exclusion for Iowa individual income tax can only be claimed in the year in which the ordinary or capital gain income was reported on the federal income tax return.

In order for an involuntary conversion to qualify for this exclusion, the sale must occur due to the requisition or condemnation, or its threat or imminence, if it takes place in the presence of, or under the threat or imminence of, legal coercion relating to a requisition or condemnation. There are numerous federal revenue rulings, court cases and other provisions relating to the definitions of the terms "threat" and "imminence," and these are equally applicable to the exclusion of ordinary or capital gains realized for tax years beginning on or after January 1, 2006.

40.69(1) *Reporting requirements.* In order to claim an exclusion of ordinary or capital gain income realized as a result of involuntary conversion of property due to eminent domain, the taxpayer must attach a statement to the Iowa individual income tax return in the year in which the exclusion is claimed. The statement should state the date and details of the involuntary conversion, including the amount of the gain being excluded and the reasons why the gain meets the qualifications of an involuntary conversion relating to eminent domain. In addition, if the gain results from the sale of replacement property as outlined in subrule 40.69(2), information must be provided in the statement on that portion of the gain that qualified for the involuntary conversion.

40.69(2) *Claiming the exclusion when gain is not recognized for federal tax purposes.* For federal tax purposes, an ordinary or capital gain is not recognized when the converted property is replaced with

property that is similar to, or related in use to, the converted property. In those cases, the basis of the old property is simply transferred to the new property, and no gain is recognized. In addition, when property is involuntarily converted into money or other unlike property, any gain is not recognized when replacement property is purchased within a specified period for federal tax purposes.

For Iowa individual income tax purposes, no exclusion will be allowed for ordinary or capital gain income when there is no gain recognized for federal tax purposes. The exclusion will only be allowed in the year in which ordinary or capital gain income is realized due to the disposition of the replacement property for federal tax purposes, and the exclusion is limited to the amount of the ordinary or capital gain income relating to the involuntary conversion. The basis of the property for Iowa individual income tax purposes will remain the same as the basis for federal tax purposes and will not be altered because of the exclusion allowed for Iowa individual income tax.

EXAMPLE: In 2007, taxpayer sold some farmland as a result of an involuntary conversion relating to eminent domain and realized a gain of $50,000. However, the taxpayer purchased similar farmland immediately after the sale, and no gain was recognized for federal tax purposes. Therefore, no exclusion is allowed on the 2007 Iowa individual income tax return. In 2009, taxpayer sold the replacement farmland that was not subject to an involuntary conversion and realized a total gain of $70,000, which was reported on the 2009 federal income tax return. The taxpayer can claim a deduction of $50,000 on the 2009 Iowa individual income tax return relating to the gain that resulted from the involuntary conversion.

This rule is intended to implement Iowa Code section 422.7.

701—40.70(422) Exclusion of income from sale, rental or furnishing of tangible personal property or services directly related to production of film, television or video projects.

40.70(1) *Projects registered on or after January 1, 2007, but before July 1, 2009.* For tax years beginning on or after January 1, 2007, a taxpayer who is a resident of Iowa may exclude, to the extent included in federal adjusted gross income, income received from the sale, rental or furnishing of tangible personal property or services directly related to the production of film, television, or video projects that are registered with the film office of the Iowa department of economic development.

Income which can be excluded on the Iowa return must meet the criteria of a qualified expenditure for purposes of the film qualified expenditure tax credit as set forth in rule 701—42.37(15,422). See rule 701—38.17(422) for the determination of Iowa residency.

However, if a taxpayer claims this income tax exclusion, the same taxpayer cannot also claim the film qualified expenditure tax credit as described in rule 701—42.37(15,422). In addition, any taxpayer who claims this income tax exclusion cannot have an equity interest in a business which received a film qualified expenditure tax credit. Finally, any taxpayer who claims this income tax exclusion cannot participate in the management of the business which received the film qualified expenditure tax credit.

EXAMPLE:A production company which registers with the film office for a project is a limited liability company with three members, all of whom are Iowa residents. If any of the three members receives income that is a qualified expenditure for purposes of the film qualified expenditure tax credit, such member(s) cannot exclude this income on the Iowa income tax return because the member(s) has an equity interest in the business which received the credit.

40.70(2) *Projects registered on or after July 1, 2009.* For tax years beginning on or after July 1, 2009, a taxpayer who is a resident of Iowa may exclude no more than 25 percent of the income received from the sale, rental or furnishing of tangible personal property or services directly related to the production of film, television, or video projects that are registered with the film office of the Iowa department of economic development in the year in which the qualified expenditure occurred. A reduction of 25 percent of the income is allowed to be excluded for the three subsequent tax years.

EXAMPLE:An Iowa taxpayer received $10,000 in income in the 2010 tax year related to qualified film expenditures for a project registered on February 1, 2010. The $10,000 was reported as income

on taxpayer's 2010 federal tax return. Taxpayer may exclude $2,500 of income on the Iowa individual income tax return for each of the tax years 2010-2013.

This rule is intended to implement Iowa Code section 15.393 as amended by 2009 Iowa Acts, Senate File 480, section 5, and Iowa Code section 422.7.

[**ARC 8589B**, IAB 3/10/10, effective 4/14/10; **ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—40.71(422) Exclusion for certain victim compensation payments. Effective for tax years beginning on or after January 1, 2007, a taxpayer may exclude from Iowa individual income tax any income received from certain victim compensation payments to the extent this income was reported on the federal income tax return. The amounts which may be excluded from income include the following:

1. Victim compensation awards paid under the victim compensation program administered by the department of justice in accordance with Iowa Code section 915.81, and received by the taxpayer during the tax year.
2. Victim restitution payments received by a taxpayer during the tax year in accordance with Iowa Code chapter 910 or 915.
3. Damages awarded by a court, and received by a taxpayer, in a civil action filed by a victim against an offender during the tax year.

This rule is intended to implement Iowa Code section 422.7 as amended by 2007 Iowa Acts, Senate File 70.

701—40.72(422) Exclusion of Vietnam Conflict veterans bonus.

40.72(1) For tax years beginning on or after January 1, 2007, a taxpayer who received a bonus under the Vietnam Conflict veterans bonus program may subtract, to the extent included in federal adjusted gross income, the amount of the bonus received. The Vietnam Conflict veterans bonus is administered by the Iowa department of veterans affairs, and bonuses of up to $500 are awarded to residents of Iowa who served on active duty in the armed forces of the United States between July 1, 1973, and May 31, 1975.

40.72(2) For tax years beginning on or after January 1, 2008, a taxpayer who received a bonus under the Vietnam Conflict veterans bonus program may subtract, to the extent included in federal adjusted gross income, the amount of the bonus received. The Vietnam Conflict veterans bonus is administered by the Iowa department of veterans affairs. Bonuses of up to $500 are awarded to veterans who were inducted into active duty service from the state of Iowa, who served on active duty in the United States armed forces from July 1, 1958, through May 31, 1975, and who have not received a bonus for that service from Iowa or another state.

This rule is intended to implement Iowa Code section 422.7 as amended by 2008 Iowa Acts, House File 2283.

701—40.73(422) Exclusion for health care benefits of nonqualified tax dependents. Effective for tax years beginning on or after January 1, 2009, but beginning before January 1, 2011, a taxpayer may exclude from Iowa individual income tax the income reported from including nonqualified tax dependents on the taxpayer's health care plan, to the extent this income was reported on the federal income tax return.

40.73(1) *Term of coverage.* Iowa Code section 509A.13B provides that group insurance, group insurance for public employees, and individual health insurance policies or contracts permit continuation of existing coverage for an unmarried child of an insured or enrollee, if the insured or enrollee so elects. If the election is made, it will be in effect through the policy anniversary date on or after the date the child marries, ceases to be a resident of Iowa, or attains the age of 25, whichever occurs first, so long as the unmarried child maintains full-time status as a student in an accredited institution of postsecondary education. These children can be included on the health care coverage even though they are not claimed as a dependent on the federal and Iowa income tax returns.

40.73(2) *Federal treatment.* Section 105(b) of the Internal Revenue Code provides that the income reported from including dependents on the taxpayer's health care coverage is exempt from federal income

tax. However, income is reported for federal income tax purposes on the value of the health care coverage of children who are not claimed as dependents on the taxpayer's federal and Iowa income tax returns for tax years beginning on or after January 1, 2009, but beginning before January 1, 2011. The amount of income included on the federal income tax return is allowed to be excluded on the Iowa return. For tax years beginning on or after January 1, 2011, income is no longer reported on the federal income tax return on the value of health care coverage of children who are not claimed as dependents and who have not attained age 27 as of the end of the tax year; therefore, no adjustment is required on the Iowa return.

This rule is intended to implement Iowa Code section 422.7 as amended by 2011 Iowa Acts, Senate File 512.

[**ARC 8605B**, IAB 3/10/10, effective 4/14/10; **ARC 9820B**, IAB 11/2/11, effective 12/7/11]

701—40.74(422) Exclusion for AmeriCorps Segal Education Award. Effective for tax years beginning on or after January 1, 2010, a taxpayer may exclude from Iowa individual income tax any amount of AmeriCorps Segal Education Award to the extent the education award was reported as income on the federal income tax return. The AmeriCorps Segal Education Award is available to individuals who complete a year of service in the AmeriCorps program. The education award can be used to pay education costs at institutions of higher learning, for educational training, or to repay qualified student loans.

This rule is intended to implement Iowa Code section 422.7 as amended by 2009 Iowa Acts, Senate File 482.

[**ARC 8605B**, IAB 3/10/10, effective 4/14/10]

701—40.75(422) Exclusion of certain amounts received from Iowa veterans trust fund. For tax years beginning on or after January 1, 2010, a taxpayer may subtract, to the extent included in federal adjusted gross income, the amounts received from the Iowa veterans trust fund related to travel expenses directly related to follow-up medical care for wounded veterans and their spouses and amounts received related to unemployment assistance during a period of unemployment due to prolonged physical or mental illness or disability resulting from military service.

This rule is intended to implement Iowa Code section 422.7 as amended by 2010 Iowa Acts, House File 2532.

[**ARC 9103B**, IAB 9/22/10, effective 10/27/10]

701—40.76(422) Exemption of active duty pay for armed forces, armed forces military reserve, or the national guard. For tax years beginning on or after January 1, 2011, all pay received from the federal government for military service performed while on active duty status in the armed forces, armed forces military reserve, or the national guard is excluded to the extent the pay was included in federal adjusted gross income.

40.76(1) Definition of active duty personnel. Active duty personnel who qualify for the exclusion include the following:

a. Active duty members of the regular armed forces, which include the Army, Navy, Marines, Air Force and Coast Guard of the United States.

b. Members of a reserve component of the Army, Navy, Marines, Air Force and Coast Guard who are on an active duty status as defined in Title 10 of the United States Code.

c. Members of the national guard who are in an active duty status as defined in Title 10 of the United States Code.

40.76(2) Military personnel who do not qualify for the exclusion include the following:

a. Members of a reserve component of the Army, Navy, Marines, Air Force and Coast Guard who are not in an active duty status as defined in Title 10 of the United States Code.

b. Full-time members of the national guard who perform duties in accordance with Title 32 of the United States Code.

c. Other members of the national guard who are not in an active duty status as defined in Title 10 of the United States Code.

d. Other members of the national guard who do not receive pay from the federal government.

40.76(3) Income from nonmilitary activities. Any wages earned from nonmilitary wages for personal services conducted in Iowa by both residents and nonresidents of Iowa will still be subject to Iowa individual income tax. In addition, both residents and nonresidents of Iowa who earn income from businesses, trades, professions or occupations operated in Iowa that are unrelated to military activity will be subject to Iowa individual income tax on that income.

40.76(4) Exemption from Iowa withholding. Active duty personnel meeting the requirements of subrule 40.76(1) who are receiving pay from the federal government on or after January 1, 2011, that is exempt from Iowa individual income tax may complete an IA W-4 Employee Withholding Allowance Certificate and claim exemption from Iowa income tax for active duty pay received from the federal government.

This rule is intended to implement Iowa Code section 422.7 as amended by 2011 Iowa Acts, House File 652.

[**ARC 9822B**, IAB 11/2/11, effective 12/7/11]

701—40.77(422) Exclusion of biodiesel production refund. A taxpayer may exclude, to the extent included in federal adjusted gross income, the amount of the biodiesel production refund described in rule 701—12.18(423).

This rule is intended to implement Iowa Code section 422.7 as amended by 2011 Iowa Acts, Senate File 531.

[**ARC 9821B**, IAB 11/2/11, effective 12/7/11]

701—40.78(422) Allowance of certain deductions for 2008 tax year.

40.78(1) For the tax year beginning on or after January 1, 2008, but before January 1, 2009, the following deductions provided in the federal Emergency Economic Stabilization Act of 2008, Public Law No. 110-343, will be allowed on the Iowa individual income tax return:

a. The deduction for certain expenses of elementary and secondary school teachers allowed under Section 62(a)(2)(D) of the Internal Revenue Code.

b. The deduction for qualified tuition and related expenses allowed under Section 222 of the Internal Revenue Code.

c. The deduction for disaster-related casualty losses allowed under Section 165(h) of the Internal Revenue Code.

40.78(2) Taxpayers who did not claim these deductions on the Iowa return for 2008 as originally filed, or taxpayers who claimed these deductions on the Iowa return as filed and subsequently filed an amended return disallowing these deductions, must file an amended return for the 2008 tax year to claim these deductions. The amended return must be filed within the statute of limitations provided in 701—subrules 43.3(8) and 43.3(15). If the amended return is filed within the statute of limitations, the taxpayer is only entitled to a refund of the excess tax paid. The taxpayer will not be entitled to any interest on the excess tax paid.

This rule is intended to implement Iowa Code sections 422.7 and 422.9 as amended by 2011 Iowa Acts, Senate File 533.

[**ARC 9820B**, IAB 11/2/11, effective 12/7/11]

701—40.79(422) Special filing provisions related to 2010 tax changes.

40.79(1) For the tax year beginning on or after January 1, 2010, but before January 1, 2011, the following adjustments will be allowed on the Iowa individual income tax return:

a. The deduction for certain expenses of elementary and secondary school teachers allowed under Section 62(a)(2)(D) of the Internal Revenue Code.

b. The deduction for qualified tuition and related expenses allowed under Section 222 of the Internal Revenue Code.

c. The increased expensing allowance authorized under Section 179(b) of the Internal Revenue Code.

40.79(2) Taxpayers who did not claim these adjustments on the Iowa return for 2010 as originally filed have two options to reflect these adjustments. Taxpayer may either file an amended return for the

2010 tax year to reflect these adjustments or taxpayer may reflect these adjustments on the tax return for the 2011 tax year. If the taxpayer elects to reflect these adjustments on the 2011 tax return, the following provisions are suspended related to the claiming of the following adjustments for 2011:

a. The limitation based on income provisions and regulations of Section 179(b)(3) of the Internal Revenue Code with regard to the Section 179(b) adjustment.

b. The applicable dollar limit provision of Section 222(b)(2)(B) of the Internal Revenue Code with regard to the qualified tuition and related expenses adjustment.

40.79(3) Examples. The following noninclusive examples illustrate how this rule applies:

EXAMPLE 1: Taxpayer claimed a $150,000 Section 179 expense on the federal return for 2010. Taxpayer only claimed a $134,000 Section 179 expense on the Iowa return as originally filed for 2010. Taxpayer elects not to file an amended return for 2010, but to make the adjustment on the 2011 Iowa return. Taxpayer reported a loss from the taxpayer's trade or business on the 2011 federal return, so no Section 179 expense can be claimed on the federal return for 2011 in accordance with Section 179(b)(3) of the Internal Revenue Code. Taxpayer can claim the $16,000 ($150,000 less $134,000) difference as a deduction on the Iowa return for 2011 since the income provision of Section 179(b)(3) is suspended for Iowa tax purposes.

EXAMPLE 2: Taxpayers are a married couple who claimed a $4,000 tuition and related expenses deduction on their federal return for 2010. Taxpayers did not claim this deduction on their Iowa return as originally filed for 2010. Taxpayers elected not to file an amended return for 2010, but to make the adjustment on the 2011 Iowa return. Taxpayers reported federal adjusted gross income in excess of $160,000 on their 2011 federal return, so no deduction for tuition and related expenses can be claimed on the 2011 federal return in accordance with Section 222(b)(2)(B) of the Internal Revenue Code. Taxpayers can claim the $4,000 deduction on the Iowa return for 2011 since the dollar limit provision of Section 222(b)(2)(B) is suspended for Iowa tax purposes.

EXAMPLE 3: Taxpayer is an elementary school teacher who claimed a $250 deduction for out-of-pocket expenses for school supplies on the federal return for 2010. Taxpayer did not claim this deduction on the Iowa return as originally filed for 2010. Taxpayer elected not to file an amended return for 2010, but to make the adjustment on the 2011 Iowa return. Taxpayer also claimed a $200 deduction for out-of-pocket expenses for school supplies on the federal return for 2011. Taxpayer can claim a $450 ($250 plus $200) deduction on the Iowa return for 2011.

This rule is intended to implement 2011 Iowa Acts, Senate File 533, section 143.

[**ARC 9820B**, IAB 11/2/11, effective 12/7/11]

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CHAPTER 11
INJURED VETERANS GRANT PROGRAM

2006-2007 PROGRAM GUIDELINES

801—11.1(35A) Purpose. The legislative intent of this program is to provide immediate financial assistance to a veteran so that family members of the veteran may be with the veteran during the veteran's recovery from an injury received in the line of duty in a combat zone or in a zone where the veteran was receiving hazardous duty pay after September 11, 2001.
[**ARC 0057C**, IAB 4/4/12, effective 5/9/12]

801—11.2(35A) Grant amounts.

11.2(1) Grants will be paid by the Iowa department of veterans affairs in increments of $2,500 up to a maximum of $10,000 in the following manner:

$2,500	When veteran is medically evacuated from the combat zone following a combat-related injury.
$2,500	30 days after evacuation date if still hospitalized, receiving medical treatment or rehabilitation services by the military or Veterans Administration; does not include follow-up appointments.
$2,500	60 days after evacuation date if still hospitalized, receiving medical treatment or rehabilitation services by the military or Veterans Administration; does not include follow-up appointments.
$2,500	90 days after evacuation date if still hospitalized, receiving medical treatment or rehabilitation services by the military or Veterans Administration; does not include follow-up appointments.

11.2(2) Treatment or services must be provided in a location that is not the veteran's home of record.
[**ARC 0057C**, IAB 4/4/12, effective 5/9/12]

801—11.3(35A) Eligible veterans.

11.3(1) For purposes of this program, the term "veteran" means:

a. A resident of this state who is or was a member of the national guard, reserve, or regular component of the armed forces of the United States who has served on active duty at any time after September 11, 2001, and, if discharged or released from service, was discharged or released under honorable conditions; or

b. A nonresident of this state who is or was a member of a national guard unit located in this state prior to alert for mobilization who has served on active duty at any time after September 11, 2001, was injured while serving in the national guard unit located in this state, is not eligible to receive a similar grant from another state for that injury, and, if discharged or released from service, was discharged or released under honorable conditions.

11.3(2) In addition to the requirements set out in subrule 11.3(1), an eligible veteran must meet all of the following conditions:

a. The veteran must have sustained a combat-related injury in a combat zone or hostile fire zone; and

b. The combat-related injury was serious enough to require medical evacuation from the combat zone to a military hospital or the injury required at least 30 consecutive days of hospitalization at a military hospital; and

c. The combat-related injury was or is considered by the military to have been received in the line of duty, based upon the circumstances known at the time of evacuation or injury.

11.3(3) The veteran shall remain eligible for the grant after discharge from the military so long as the veteran continues to receive medical treatment or rehabilitation services for the specific injury or illness.

11.3(4) The commission may consider a request for a waiver of any of these requirements only pursuant to the provisions of Iowa Code section 17A.9A.
[**ARC 9471B**, IAB 4/20/11, effective 3/31/11; **ARC 0057C**, IAB 4/4/12, effective 5/9/12]

801—11.4(35A) Notification and application procedures.

11.4(1) *Retroactive application to September 11, 2001.*

a. The department will accept a consolidated roster of eligible injured veterans from a "flag officer level command" or a central casualty notification agency of the responsible service component as long as the roster includes the following information for each veteran:

(1) Veteran's name, rank, and social security number.

(2) Mailing address for check disbursement.

(3) Telephone numbers, including day, evening, and cell phone.

(4) Combat theater served.

(5) Date on which veteran was medically evacuated from combat theater and verification of combat-related injury.

(6) Date on which medical or rehabilitative treatment was terminated. If the veteran is still receiving treatment, "inpatient" or "outpatient" shall be noted on the form.

(7) Contact information for the agency submitting the consolidated roster, including point of contact (POC), telephone numbers, and E-mail address.

b. A veteran filing for the grant under retroactive eligibility must submit an injured veteran grant application form along with supporting documents. Supporting documents needed to verify eligibility shall include copies of the following:

(1) Military ID card;

(2) DD214 (if the veteran has been discharged) or military orders to document service in a combat zone;

(3) Medical records or military orders to document date of medical evacuation and periods of continued medical treatment or rehabilitation; and

(4) Any document to establish Iowa residency at the time of injury, such as Iowa income tax forms, or to establish that the veteran is or was a member of a national guard unit located in this state prior to mobilization and was injured while serving in that national guard unit and is not eligible to receive a similar grant from another state for that injury.

A veteran may receive assistance in the application process by contacting the department office at (515)242-5331 or (800)838-4692 or by fax (515)242-5659.

11.4(2) *Process for present and future injured veterans.*

a. When the department receives official notification from a designated service office that a veteran has been medically evacuated from a combat zone, the department will confirm Iowa residency of the veteran or, in the case of a nonresident, confirm that the veteran is or was a member of a national guard unit located in this state prior to mobilization and gather the required data to disburse the first grant payment. The check will be made payable to the veteran and mailed or presented to the veteran or next of kin.

b. Grant payments will be stopped if the veteran is returned to duty or when medical or rehabilitative treatment is discontinued.

c. If an eligible combat-injured veteran is not medically evacuated, the 30 days of continuous treatment must occur within 12 months of the injury.

11.4(3) *Commission review.*

a. A three-person subcommittee of commissioners will review applications for those veterans not evacuated but requiring 30 days of consecutive treatment.

b. An applicant may appeal a grant award decision to the commission.

11.4(4) *Subsequent award.*

a. A seriously injured veteran meeting all other requirements of this rule may receive additional grants for subsequent, unrelated injuries that meet the requirements of this rule. Any subsequent,

unrelated injury shall be treated as if it were an initial injury for the purposes of determining eligibility or allotment.

b. Grants for veterans suffering subsequent, unrelated injuries after September 11, 2001, but prior to March 30, 2011, shall be payable, upon a showing that the veteran would have been eligible for payment had the subsequent, unrelated injury occurred on or after March 30, 2011.

[**ARC 9471B**, IAB 4/20/11, effective 3/31/11; **ARC 0057C**, IAB 4/4/12, effective 5/9/12]

801—11.5(35A) Taxability. An injured veterans grant is exempt from Iowa income tax since the intent of the grant is to reimburse a veteran for family travel and lodging costs during the veteran's medical treatment and rehabilitation.

These rules are intended to implement Iowa Code section 35A.14 as amended by 2011 Iowa Acts, Senate File 402.

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CHAPTER 12
COUNTY GRANT PROGRAM FOR VETERANS
Rescinded IAB 4/4/12, effective 5/9/12

CHAPTER 14
VETERANS TRUST FUND

801—14.1(35A) Purpose. These rules establish the requirements for veterans or their spouses or dependents to receive benefits from the veterans trust fund.

801—14.2(35A) Definition. For purposes of this chapter, "veteran" means the same as defined in Iowa Code section 35.1, or a resident of Iowa who served in the armed forces of the United States, completed a minimum aggregate of 90 days of active federal service, other than training, and was discharged under honorable conditions, or a former member of the national guard, reserve, or regular component of the armed forces of the United States who was honorably discharged due to injuries incurred while on active federal service that precluded completion of a minimum aggregate of 90 days of active federal service, other than training.
[**ARC 7823B**, IAB 6/3/09, effective 7/8/09]

801—14.3(35A) Eligibility. Veterans, their spouses, and their dependents applying for benefits available under subrules 14.4(1) through 14.4(9) must meet the following threshold requirements.

14.3(1) *Income.* For the purposes of this chapter, an applicant's household income, including VA pension benefits, service-connected disability income, and social security income, shall not exceed 200 percent of the federal poverty guidelines for the number of family members living in the primary residence in effect on the date the application is received by the county director of veterans affairs. Federal poverty guidelines shall be those guidelines established by the Iowa department of human services for the veteran's family size. The commission shall adjust the guidelines on July 1 of each year to reflect the most recent federal poverty guidelines. The commission may waive the income threshold if all income is from a fixed source and all other sources of assistance have been exhausted.

14.3(2) *Resources.* The department may not pay benefits under this chapter if the available liquid assets of the veteran are in excess of $15,000. For the purposes of this chapter, "available liquid assets" means cash on hand, cash in a checking or savings account, stocks, bonds, certificates of deposit, treasury bills, money market funds and other liquid investments owned individually or jointly by the applicant and the applicant's spouse, unless the applicant and spouse are separated or are in the process of obtaining a divorce, but does not include funds deposited in IRAs, Keogh plans or deferred compensation plans, unless the veteran is eligible to withdraw such funds without incurring a penalty. Cash surrender value of life insurance policies, real property, established burial account, or a personal vehicle shall not be included as available liquid assets.

14.3(3) *Funding from other sources.* Applications shall not be approved if the applicant is eligible to receive aid from other sources to meet the purposes authorized in this chapter.

14.3(4) *Additional requirements and limitations.* Applicants must meet any additional requirements and are subject to any limitations which may be set out in this chapter or which may be established for a particular benefit.
[**ARC 7823B**, IAB 6/3/09, effective 7/8/09; **ARC 0057C**, IAB 4/4/12, effective 5/9/12]

801—14.4(35A) Benefits available. Applications may be approved for any of the following purposes. By a majority vote, the commission may suspend some or all of these benefits for payment.

14.4(1) *Travel expenses for wounded veterans, and their spouses, directly related to follow-up medical care.* Travel expenses under this subrule include the unreimbursed cost of airfare, lodging, and a per diem of $25 per day for required out-of-state medical travel that exceeds 125 miles from the veteran's home. Spouses may be reimbursed for in-state lodging and a per diem of $25 per day when visiting a veteran who is in a hospital for medical care related to a service-connected disability. The distance from the veteran's home to the hospital must exceed 100 miles. The veteran or the veteran's spouse shall provide such evidence as the commission may require, which includes but is not limited to evidence the injury or disability is service-connected, the necessity of treatment in a particular facility, and documentation of expenses. The maximum amount for lodging reimbursement shall be $90. The

maximum amount of aid payable in a consecutive 12-month period under this subrule is $1,000. The commission may waive the income threshold for this benefit.

14.4(2) *Job training or college tuition assistance for job retraining.*

a. The commission may pay a veteran not more than $3,000 for retraining or postsecondary education to enable the veteran to obtain gainful employment. The commission may provide aid under this subrule if all of the following apply:

(1) The veteran is enrolled in a training course in a technical college or school, is enrolled in an accredited postsecondary institution, or is engaged in a structured on-the-job training program.

(2) The veteran is unemployed, underemployed, or has received a notice of termination of employment.

(3) The commission determines that the veteran's proposed program, or current program, will provide retraining or initial training that could enable the veteran to find gainful employment. In making its determination, the commission shall consider whether the proposed program, or current program, provides adequate employment skills and is in an occupation for which favorable employment opportunities are anticipated.

(4) The veteran requesting aid has not received full reimbursement or payment from any other retraining or education scholarship programs and the veteran does not have other assets or income available to meet retraining or initial training expenses. Applicants requesting aid under this subrule will only be granted the unpaid portion of their tuition statement, and the payment will be made directly to the institution.

b. The veteran shall provide such evidence as the commission may require to satisfy the requirements of this subrule.

14.4(3) *Unemployment or underemployment assistance during a period of unemployment or underemployment due to prolonged physical or mental illness resulting from military service or disability resulting from military service.* The commission may provide subsistence payments only to a veteran who has suffered a loss of income due to prolonged physical or mental illness resulting from military service or disability resulting from military service. The commission may provide subsistence payments of up to $500 per month of unemployment or underemployment to a veteran. No payment may be made under this subrule if the veteran has other assets or income available to meet basic subsistence needs. A period of unemployment implies that it is possible for the veteran to be employed in the future. A rating from the VA of 100 percent due to individual unemployability (IU) rated permanent and total indicates that a veteran is unemployable and will not qualify for assistance under this subrule. The veteran shall provide such evidence as the commission may require, which includes but is not limited to evidence that the mental illness or disability is service-connected and evidence that the veteran is unemployed or underemployed for the period of payments. To qualify as underemployed, the applicant must be currently working at an income that is below 150 percent of federal poverty guidelines due to limitations caused by the applicant's service-connected disability or illness. The maximum amount of aid payable in a consecutive 12-month period under this subrule is $3,000 and a lifetime maximum of $6,000.

14.4(4) *Expenses related to hearing care, dental care, vision care, or prescription drugs.*

a. The commission may provide health care aid to a veteran, to the veteran's spouse or dependents, or to the unremarried spouse of a deceased veteran for dental care, including dentures; vision care, including eyeglass frames and lenses; hearing care, including hearing aids; and prescription drugs that are not covered by the Veterans Affairs medical center.

b. The maximum amount that may be paid under this subrule for any consecutive 12-month period may not exceed $2,500 for dental care, $500 for vision care, $1,500 per ear for hearing care, and $1,500 for prescription drugs.

c. The commission shall not provide health care aid under this subrule unless the aid recipient's health care provider agrees to accept, as full payment for the health care provided, the amount of the payment; the amount of the recipient's health insurance or other third-party payments, if any; and the amount that the commission determines the veteran is capable of paying. Payment under this subrule

will be provided directly to the health care provider. The commission shall not pay health care aid under this subrule if the available liquid assets of the veteran are in excess of $5,000.

d. Applicants for assistance under this subrule will be required to provide the commission with an unpaid bill for service or an estimated cost of service from the health care provider and documentation of the need for the service. For prescription drugs, the applicant must produce documentation of the need for the prescribed drug and documentation stating whether a generic drug is available or appropriate. The commission payment will not exceed an estimated cost of service by a health care provider.

14.4(5) *Expenses relating to the purchase of durable equipment or services to allow a veteran, the veteran's spouse or dependents, or the unremarried spouse of a deceased veteran to remain in their home.*

a. The commission may make reimbursement payments to a veteran or to the unremarried spouse of a deceased veteran for the purchase of durable equipment that allows the veteran, the veteran's spouse or dependents, or the unremarried spouse of a deceased veteran to remain in their home or allows them the ability to utilize more of their home.

b. Individuals requesting reimbursement under this subrule will be required to provide verification of the purchase and installation of the equipment and information relating to the need for the equipment. Individuals may also provide a product and installation cost estimate to the commission for approval, with the understanding that the commission will pay no more than the cost estimate to the supplier or installer. Applicants needing durable equipment as a medical necessity should provide information from a physician.

c. Assistance under this subrule cannot duplicate assistance from other entities, and the maximum amount that may be paid may not exceed $2,500.

d. The commission shall not pay a reimbursement under this subrule if the available liquid assets of the veteran are in excess of $5,000.

14.4(6) *Individual counseling or family counseling programs.*

a. The commission may make mental health, substance abuse, and family counseling available to veterans and their families. Individual family members are eligible for counseling.

b. The assistance may include appropriate counseling and treatment programs for veterans and their families in need of services.

c. Any assistance provided under this subrule shall not duplicate other services readily available to veterans and their families. Veterans who are eligible for VA mental health services must initially visit their nearest VA medical facility for initial consultation and continued psychiatric treatment. Payment under this subrule will be made for additional services for the veteran in a location closer to the veteran's home and at a greater frequency than the VA medical center can accommodate.

d. The commission may provide up to $150 per hour and $75 per half-hour for outpatient counseling visits to providers who will accept as full payment for the counseling services the amount provided. Counseling and substance abuse services provided in a group setting may be paid up to $40 per hour. Counseling and substance abuse services may also be provided in an inpatient setting, subject to the maximum amount eligible under 14.4(6)*"f."*

e. The maximum amount that may be paid under this subrule for any consecutive 12-month period shall not exceed $5,000. Individuals seeking counseling services are eligible for up to $2,500, individuals seeking substance abuse treatment and counseling combined are eligible for up to $3,500, and families seeking counseling services that may also include individual counseling and substance abuse services are eligible for up to $5,000.

f. The commission may not provide counseling under this subrule unless the aid recipient's counseling service provider agrees to accept, as full payment for the counseling services provided, the amount of the payment; the amount of the recipient's health insurance or other third-party payments, if any; and the amount that the commission determines the veteran is capable of paying. The commission will make payment directly to the entity providing counseling and substance abuse services. The commission shall not pay for counseling under this subrule if the available liquid assets of the veteran are in excess of $5,000.

14.4(7) *Expenses relating to ambulance and emergency room services for veterans.*

a. The commission may provide assistance to veterans for expenses related to ambulance trips, including air ambulance transportation, and emergency room visits for emergency care patients or VA health care patients that cannot indicate to emergency personnel that they are to be presented to a VA medical center.

b. Funding through this subrule shall be paid directly to the entity providing the emergency service or transportation after the commission is provided with an unpaid bill. All efforts should be made to utilize all other methods of payment prior to accessing assistance under this subrule.

c. The maximum amount that may be paid under this subrule may not exceed $5,000.

14.4(8) *Emergency expenses related to vehicle repair, housing repair, or temporary housing assistance.*

a. The commission may provide assistance to a veteran or to the unremarried spouse of a deceased veteran for emergency vehicle repair, emergency housing repair, and temporary housing.

b. Assistance for vehicle repair is limited to expenses that are required for continued use of the vehicle. This assistance will only be granted in cases where the vehicle is needed for travel to and from work-related activities, the applicant is over the age of 65, or substantial hardship will occur if the vehicle is not repaired. Assistance may be provided in situations where the applicant does not have sufficient means to pay an insurance deductible. Assistance may be paid directly to the entity performing the maintenance or the insurance company owed the deductible. In certain circumstances, reimbursement may be made to the veteran or to the unremarried spouse of a deceased veteran in order for the vehicle to be released from the entity providing the service. Assistance will not be provided for damage caused during the commission of a crime, for cosmetic needs, for damage resulting in an auto accident when automobile insurance has not been purchased, or for routine maintenance.

c. Assistance for home repair is limited to repairs that are required to improve the conditions and integrity of the home and are necessary for the safety and security of the residents. Applicants with homeowners insurance may request assistance for payment of a deductible. Assistance may be provided for applicants in disaster situations, home accidents, vandalism, or other situations as determined by the commission. In situations where a home is damaged beyond repair, assistance under this subrule is available to assist the applicant in purchasing a new home.

d. Assistance for transitional housing may be provided to applicants who are displaced from their home during a period of repairs related to a disaster, vandalism, home accident, or other reason that makes staying in the home hazardous to the health of the residents. Any refunded security deposits paid for under this subrule shall be returned to the Iowa veterans trust fund.

e. The maximum amount that may be paid under this subrule for any consecutive 12-month period may not exceed $2,500 for vehicle repair, $3,000 for housing repair, and $1,000 for transitional housing.

f. The commission shall not pay a reimbursement under this subrule if the available liquid assets of the veteran are in excess of $3,000.

14.4(9) *Expenses related to establishing whether a minor child is a dependent of a deceased veteran.*

a. The commission may provide assistance to the family of veterans who are killed while serving on active federal service, for expenses related to paternity or maternity tests or the cost of procuring additional DNA samples from the deceased veteran. This assistance is available to determine whether a child is eligible for United States Department of Veterans Affairs war orphan benefits.

b. Applicants are required to provide the results of the paternity or maternity examinations to the commission upon completion of the tests. Where the deceased veteran is not the parent of the child, the applicant will be required to repay the assistance received as provided in 801—14.6(35A).

c. The maximum amount that may be paid under this subrule is $2,500.

d. The commission may waive the income threshold for this benefit.

14.4(10) *Family support group programs or programs for children of members of the military.*

a. The commission may award grants to unit family readiness/support groups, family support offices, and other such organizations providing support and programs to families and children of family members.

b. The grant shall be only for projects or programs which are not funded from any other source. The commission shall determine if the applicant's proposed project or program will provide the intended support. In making its determination, the commission shall consider whether the proposed program will provide anticipated favorable results.

c. The maximum amount of aid payable in a consecutive 12-month period under this subrule to a family readiness/support group is $500.

14.4(11) *Honor guard services.*

a. The commission may reimburse veterans organizations for providing military funeral honors as follows:

(1) If a single veterans organization provides basic honors, $25.

(2) If a single veterans organization provides full honors, $50.

(3) If two or more veterans organizations participate in providing full honors and one of the organizations provides a firing detail, $50. The organizations may request that the commission split the reimbursement.

(4) If two or more veterans organizations participate in providing basic honors, $25. Payment shall be to one veterans organization, as determined by the commission.

b. Notwithstanding paragraph *"a,"* the commission shall not reimburse a veterans organization if federal funding is available to reimburse the veterans organization for providing military funeral honors. The veterans organization shall request reimbursement from federal sources. If a veterans organization receives federal funding for providing military funeral honors at the reimbursement rate of one funeral per day, the department shall reimburse the organization for the provision of military funeral honors at any additional funerals on that day.

c. The maximum amount of aid payable in a calendar year under this subrule to a veterans organization is $500.

d. Veterans service organizations that are not currently providing honor guard services may apply for a $500, up-front grant, for the use of creating a new honor guard within their organization. Applicants must present the commission with an estimated cost for purchasing uniforms and firearms for providing military honors and an estimated number of members who will be available to perform honor guard services. Organizations should also provide information regarding how they plan to pay for additional expenses that may occur outside of trust fund assistance. Applicants will be eligible for reimbursements under 14.4(11)*"a"* to *"c"* 12 months after the receipt of their original $500 grant.

14.4(12) *Matching funds to veterans service organizations to provide for accredited veteran service officers.*

a. The commission may provide matching funds to veterans service organizations for maintaining accredited veteran service officers located at the Des Moines Veterans Affairs Regional Office.

b. Funding for all service organizations combined is available in an amount of up to 20 percent of the interest and earnings on the trust fund balance during the fiscal year or $150,000, whichever is less.

c. Service organizations requesting funding from the trust fund must provide financial data on the level of organizational funding for the staffing and operation of an office in the Des Moines Veterans Affairs Regional Office. Of the available amount outlined in this subrule, assistance will be split evenly among the service organizations eligible for the trust fund assistance. If the service organization's expenditures are less than their share of the grant, the grant amount will be reduced to the amount of their previous fiscal year's expenditures.

d. Service organizations will be required to maintain the same level of expenditures in the year they receive funding as in the previous year. Funding will be recaptured by the treasurer of the state of Iowa if this funding is used to supplant funding from an individual veterans service organization. Trust fund assistance will not be included in future fiscal year maintenance of effort requirements. A report on the previous fiscal year's expenditures will be required to determine the maintenance of effort for the organization.

[**ARC 7823B**, IAB 6/3/09, effective 7/8/09; **ARC 0057C**, IAB 4/4/12, effective 5/9/12]

801—14.5(35A) Application procedure. Applications for benefits from the veterans trust fund may be obtained at any county veterans affairs office. The county director of veterans affairs shall date-stamp the application and submit it to the Iowa Department of Veterans Affairs, Camp Dodge, Bldg. A6A, 7105 NW 70th Avenue, Johnston, Iowa 50131-1824.

14.5(1) *Application process.* A person who wishes to apply shall complete an Application for Veterans Trust Fund form and provide such documentation or other evidence as the commission may require in order to determine the awarding or denial of the benefits available under this chapter.

14.5(2) *Date of application.* The date of the application shall be the date the signed application and written verification are received by the Iowa department of veterans affairs.

14.5(3) *Eligibility determination.*

a. The county director of veterans affairs or members of the county commission shall make a recommendation to the Iowa commission of veterans affairs as to whether to approve or deny the application. The Iowa commission of veterans affairs or a subcommittee appointed by the chair shall approve or deny all applications. Applications submitted to the Iowa commission of veterans affairs will be processed at its quarterly meetings as set forth in 801—paragraph 1.2(2)*"a"* or during a conference call for the purpose of voting on a trust fund expenditure. Applications must be approved by a majority vote of the commission membership or appointed subcommittee. The director of the Iowa department of veterans affairs shall notify an applicant within 15 days of the commission's decision. An explanation of the reasons for rejection of an application will accompany denials.

b. Applications for honor guard reimbursements under subrule 14.4(11) shall be processed solely by the Iowa department of veterans affairs and do not need commission approval for expenditure of trust fund interest balance funds for this purpose.

14.5(4) *Waiting list.* After all veterans trust fund moneys have been obligated, the commission shall approve or deny pending applications based on eligibility. Applicants who meet the eligibility requirements and are approved for payment by the commission shall be placed on a waiting list based on the date of approval and then according to the order in which the completed applications and verification were received by the Iowa commission of veterans affairs. In the event that more than one application is received at one time, the applicant shall be entered on the waiting list on the basis of the applicant's birthday, the oldest applicant being first on the waiting list.

[**ARC 7823B**, IAB 6/3/09, effective 7/8/09]

801—14.6(35A) Recovery of erroneous payments.

14.6(1) *Erroneous payments.* The commission may recover payments made as a grant under this chapter if any of the following apply:

a. The information provided by the applicant is inaccurate.

b. The commission incorrectly calculated the grant amount.

c. The applicant is not entitled to a grant or is entitled to a lower grant amount as a result of a change in circumstances that affects the applicant's eligibility to receive the grant.

14.6(2) *Amount of recovery.* The commission may recover only the portion of the grant to which the applicant would not have been entitled if the correct information had been provided or if the grant had been properly calculated or as a change in circumstances warrants.

14.6(3) *Remedies.* The commission may request repayment of the amount due under subrule 14.6(2). In lieu of a lump-sum payment, the commission may enter into an agreement under which the applicant may repay the amount due within a 12-month period. If the applicant fails to repay the amount due within 30 days of a request for repayment or fails to comply with the terms of a repayment agreement, the commission may offset future grants that the applicant may be entitled to under this chapter until the amount due has been recovered. The commission may also suspend other benefits available to the applicant until the amount due has been recovered.

14.6(4) *Waiver.* The commission may temporarily or permanently waive its authority to recover payments under subrule 14.6(1) or suspend benefits under subrule 14.6(3) if the applicant's household income is totally exempt from Iowa garnishment law.

14.6(5) *Appeal.* Any commission decision under this chapter is subject to appeal under rule 801—14.7(35A).

801—14.7(35A) Appeal rights.

14.7(1) *Subcommittee action.* An applicant may appeal the decision of the subcommittee to the full Iowa commission of veterans affairs. The applicant shall appeal the decision of the subcommittee to the commission in writing within 30 days of receiving the written denial and shall provide relevant new information to substantiate the appeal.

14.7(2) *Final agency action.* The approval or denial of an application by the commission or by the department shall be the final decision of the agency.

14.7(3) *Judicial review.* Judicial review of the commission's or department's final decisions may be sought in accordance with Iowa Code section 17A.19.

[**ARC 7823B**, IAB 6/3/09, effective 7/8/09]

These rules are intended to implement Iowa Code section 35A.13 as amended by 2007 Iowa Acts, House File 817, section 7.

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CHAPTER 17
VETERANS LICENSE FEE FUND

801—17.1(35A) Purpose. These rules establish authorized expenditures from the veterans license fee fund.
[**ARC 0057C**, IAB 4/4/12, effective 5/9/12]

801—17.2(35A) Moneys. Moneys in this fund may be used for the administrative expenses related to the business of the Iowa commission of veterans affairs, to include mileage, per diem, conference call capabilities, printing costs for quarterly meetings, and expenses incurred for hearings at the Iowa Veterans Home.
[**ARC 0057C**, IAB 4/4/12, effective 5/9/12]

801—17.3(35A) Expenditures. Moneys in this fund may be used for expenditures that have the intent to benefit all Iowa veterans. (Examples include benefit books, educational materials, and research.)
[**ARC 0057C**, IAB 4/4/12, effective 5/9/12]

801—17.4(35A) Administration. This fund will be administered by the department.
[**ARC 0057C**, IAB 4/4/12, effective 5/9/12]

These rules are intended to implement Iowa Code section 35A.11.

[Filed ARC 0057C (Notice ARC 9939B, IAB 12/28/11), IAB 4/4/12, effective 5/9/12]